

Karen Tan, ND, MAcOM, LAc.
320 Ward Ave, Suite 105
Honolulu, HI 96814
(808) 591-8778

Patient Profile

Name: _____ Age: _____ Date of Birth: _____ Sex: _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone: (Home) _____ (Work) _____ (Cell) _____
Email _____ May we send you emails? _____
Occupation: Full or Part Time: _____
Employer: _____
Address: _____ City: _____ State: _____ Zip: _____
Referred by: _____ May we thank them? _____
Next of kin (or emergency name): _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone: (Home) _____ (Work) _____ (Cell) _____

CURRENT HEALTH CONDITION

When, where and from whom did you last receive medical or health care?

What are your most important health concerns?

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Do you have any contagious diseases at this time: Yes No

If yes, what? _____

CURRENT MEDICATIONS

Do you take or use:

- | | | | |
|--|--|--|--------------------------------------|
| <input type="checkbox"/> Laxatives | <input type="checkbox"/> Pain relievers | <input type="checkbox"/> Antacids | <input type="checkbox"/> Cortisone |
| <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Thyroid medication | <input type="checkbox"/> Sleeping pills | <input type="checkbox"/> Antibiotics |
| <input type="checkbox"/> Appetite suppressants | <input type="checkbox"/> Nasal decongestants | <input type="checkbox"/> Birth control pills | <input type="checkbox"/> Hormones |

Please list any prescription or over-the-counter medications, vitamins or other supplements you are taking and dosages:

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Do you have any known allergies? Yes No

If yes, please list them _____

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Acknowledgment & Agreement of Terms

Our goal is to assist you in achieving improved health. We shall work with your body's inherent ability to heal encompassed in the laws of nature.

This agreement clarifies our billing procedures. Please carefully read the statements below. Your signature designates your understanding and consent to these procedures.

Please contact us with any questions, if necessary, prior to returning this form.

- 1) All accounts are due at the time of your visit. Cash, check, MasterCard, and Visa are acceptable methods of payment.
- 2) It is your responsibility to determine whether or not your insurance company will reimburse you for your visit(s), and to what degree. We provide the proper paperwork,
- 3) Services and treatments not covered by your insurance carrier will still be your personal responsibility for payment to Dr Karen Tan.
- 4) We provide adjunctive, ongoing care. This means that care rendered by our physicians will not replace your need for a primary care physician. Our physicians subscribe to no hospital plans in the area, and therefore do not have admitting privileges.
- 5) The fee for an initial consultation, which includes a detailed history, physical exam, and a treatment program is \$165. Return visits are \$95. These fees are subject to change without prior notice. Initial allergy assessment is \$165 and subsequent treatments are \$95.
- 6) If you have HMAA or UHA, you will be responsible for the copay as well as the portion of the above stated fees that is not covered by your insurance. Please provide a copy of your insurance card and fill out the insurance claim form.
- 7) A 24 hour notice is required if you cannot make the next scheduled appointment. If you change or cancel the appointment within 24 hours, you will be charged for the visit.

Signature: _____ Date: _____

INFORMED CONSENT

In signing below, I acknowledge that Karen Tan, ND, MAcOM, LAc, has disclosed to me the following items concerning my treatment:

1. The care being provided is not a treatment for a specific disease, but preventative in nature and designed to improve my health or condition.
2. That she is not recommending I discontinue any other treatment or care being provided by any other health care professional.
3. That there is no guarantee or warrantee, expressed or implied, concerning the outcome of any procedures.
4. That full disclosure of information has been made regarding my condition, the nature and character of the proposed treatment and/or procedure, the anticipated results, and the recognized serious possible risks, complications, if any, and anticipated benefits involved in the treatment and/or procedure, and in the recognized possible alternative forms of treatment, including non-treatment.
5. That I have had any questions answered to my satisfaction regarding my treatment, and I have agreed to the treatment and/or procedures that Dr. Tan will provide.
6. That should I experience any difficulties regarding my treatment, I am to contact Dr Tan as soon as possible, or proceed to the nearest emergency room.

Patient or legal guardian

date