

**Before your treatment, please roll up your sleeves
and remove wristwatch and bracelets.**

Bluegrass Chinese Medicine
7505 New La Grange Road
Louisville, KY 40222
Jeffrey C. Russell M.S., C.Ac.

Patient Information:

Name: _____ Today's date: _____

Address: _____

City: _____ State: _____ Zip: _____

Gender: M F Age: _____ DOB: _____

Home Phone _____ Cell _____ Work _____

Married Significant Other Single Divorced

Children? Yes No If so, how many? _____

Have you ever received Chinese Medicine? Yes No

Emergency Contact

Name _____ Relationship _____

Phone cell/home _____ Work _____

Who may we thank for referring you? _____

Employment Status:

Full-time Part-time Retired Unemployed Student

Occupation _____ Employer _____

Medications:

Are you currently taking any medications? Yes No

If so, please list them: _____

Bluegrass Chinese Medicine
2240 Taylorsville Road
Louisville, KY 40205
Jeffrey C. Russell M.S., C.Ac.

Do you currently have or suspect that you have one of the following conditions for which you are currently *not* under physician care?

Please check any that apply:

- Hypertension or cardiac conditions
- Acute, severe abdominal pain
- Undiagnosed neurological pain
- Unexplained weight loss or gain in excess of fifteen percent of the patient's body weight in less than a three month period
- Suspected fracture or dislocation
- Suspected systemic infection
- Suspected hemorrhagic disorder
- Acute respiratory distress without a previous history
- Pregnancy
- Diabetes

Are you currently under the care of a physician for any of these conditions?

- Yes No

Patient Signature _____ Date _____

Bluegrass Chinese Medicine Patient Agreement:

Cancellation/no show policy:

Please be advised that we need a 24 hour notice of cancellation, otherwise you will be charged \$60.00.

Financial responsibility:

While we will assist you in billing your insurance company as much as possible, many companies have fixed allowances or percentages based on your contract with them, not our clinic. It is your responsibility to pay the deductible, co-payment, and any other balances not paid by your insurance.

Assignment and release:

I hereby assign my insurance benefits to be paid directly to the provider of service. I understand that I am financially responsible for any non-covered services. I authorize the provider to release any information required to process any claims.

Signed: _____ Date: _____

cc: Attorney O.H. Barber, Esq.