MELANIE MORRIS KATIN, L.AC.
LICENSED ACUPUNCTURIST
BOARD CERTIFIED IN CHINESE HERBOLOGY

Pediatric Health History

928 BROADWAY • # 1200
NEW YORK, NY 10010
TEL: 212.777.1318

Child's Name_____ ☐ Female ☐ Male

Parent/Guardian Name_____

Address_____ Apt._____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell_____

Parent Email_____

Child's Date of Birth_____ Age_____

Place of Birth_____

Current Physician_____ Phone_____

Whom may we thank for referring you?_____

Primary Reason For Visit:

Secondary Health Concerns:

Have you received a western biomedical diagnosis? If so, please state:

Please list all medications, and reason for use:

_____

_____

_____

_____

Please list all immunizations and at what age administered. You may attach a copy of schedule:

Please list any illnesses or hospitalizations, and age:

Any health issues during pregnancy? If yes, please describe:

Type of birth?

Any complications during labor? If yes, please describe:

Please list any known allergens:

Please list any other relevant information pertaining to your child's health (i.e. family history of disease, exposure to second hand smoke, pets, etc):

Melanie Katin, L.Ac.
Acupuncture & Chinese Herbs

INFORMED CONSENT FOR ACUPUNCTURE AND ORIENTAL MEDICINE TREATMENT

I request and consent to the performance of acupuncture and other Chinese medicine procedures. I understand that my signature on this form indicates that I have read the following, and understand that if I have any questions, I should ask the practitioner.

1. Nature of Treatment: The treatment modalities may include acupuncture, massage therapy, acupressure, cupping, gua-sha, electric acupuncture, Chinese herbs. I understand that the treatments will be explained to me prior to the treatment of my condition.
2. Purpose of Treatment: I understand that the purpose of the treatment is to resolve my condition, the reason that I am requesting treatment. The procedures will attempt to remedy bodily dysfunction or diseases, to modify or prevent the perception of pain, and to make normal the body's physiological functions.
3. Risks of Treatment: I understand that Chinese medicine procedures have been shown to be safe and effective. However, I understand that there are some uncommon risks. These may include:
   - ❖ Mild discomfort during or after the insertion of a needle, dizziness, fainting, localized bruising or swelling, gastrointestinal upset with the use of Chinese herbs, temporary aggravation of symptoms that existed prior to treatment; some herbs and acupuncture points are contraindicated during pregnancy. *Please notify your practitioner if you are or might be pregnant.*
4. Use of Disposable Needles: I understand that to prevent any possibility of infection from acupuncture, all needles used are pre-sterilized, used one time only, surgical stainless steel needles that are disposed of after usage as medical waste. Needles are never reused.
5. Unforeseen Risks: I understand that the practitioner cannot anticipate or explain all risks and complications that may occur during or after treatment. I understand that they will exercise judgment based upon their determination of my best interest. I understand that I may stop treatment at any time.

PATIENT ADVISORY TO CONSULT A PHYSICIAN

To comply with Article 160, section 8211.1(b) of NYS Education law, we must advise that you consult a physician regarding your condition.

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OFFICE POLICIES AND PROCEDURES

Appointment Policies: Please be on time for appointments.

Failure to cancel an appointment with less than 24 hours notice will result in full payment.

Please note that your insurance carrier is not responsible for this fee, you are. Your consideration is well appreciated.

HIPAA Privacy Act: Ensures that all of your personal and health information remains confidential at all times between this office, your insurance company and you. Should you have any questions about the privacy of your information at this office, you may ask Melanie Katin at any time.

Your signature indicates that you have read, understand, and agree with the above information.

Insurance Policies: I authorize payment of insurance benefits otherwise payable to me directly to the practitioner. I agree to pay for all treatment sessions, co-payments, deductibles, and coinsurances for the services performed in the event that my health insurance policy does not cover those services, or as required by my policy. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I understand that if my insurance plan does not fully cover acupuncture treatments, I will be held accountable to pay any balances due on account.

Your signature indicates that you have read, understand, and agree with the above information.

Signature of Patient (or patient representative/parent)_____Date_____