Integrative Wellness Clinic

7959 Broadway Street, Suite 602
San Antonio, TX 78209

Acupuncture Notification Form

I,_____am notifying Acupuncture San Antonio of the following:

Yes_____No_____ I have been evaluated by a physician, dentist, physician assistant or nurse practitioner for the condition being treated within six months before the acupuncture was preformed. I recognize that I should be evaluated by a physician for the condition being treated by the acupuncturist.

OR

Yes_____No_____ I have received a referral from a chiropractor within the last 30 days of acupuncture. After being referred by a chiropractor, if after 30 days or 20 treatments, whichever comes first, no substantial improvement occurs in the conditions being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice to follow this advice.

_____ _____

Patient signature (required) Date

The acupuncturist has referred me to a physician. It is my responsibility and choice to follow his/her advice.

_____ _____

Patient signature Date

_____ _____

Acupuncturist's signature Date