**Wu's Healing Center** **1014 Clement Street, San Francisco, CA 94118** **(415) 750-5050**

**Welcome to Wu's Healing Center. Here is a short introduction and orientation to our clinic and services. Please read carefully.**

**Location:** 1014 Clement Street, between 11th and 12th Avenues. The first appointment for the Fertility Program may take up to 3 hours. Subsequent visits are approximately 2 hours. **We ask that you not park at the parking meters, as they last up to two hours and we do not feed them under any circumstance.** Nearby parking is often limited to two hours, which is insufficient for most appointments, **especially your first visit.** The best option is to park south of Geary where unlimited street parking may often be found.

**Scheduling:** Because we are a busy acupuncture clinic, we recommend booking three to four appointments in advance after your first appointment. If you need to **cancel** a visit, please let us know **48 business hours** ahead of time, otherwise there will be a **late cancellation fee equal to the cost of your treatment**. A 3pm **Monday** appointment must be canceled by 3pm the previous **Friday**. **Please be on time for your appointments to avoid any unnecessary charges. Any changes to appointment length within 48 hours of your appointment time - for example, changing from a 2-hour session to a 1-hour session – will result in the full charge of the original appointment.**

**Insurance:** **If you are not sure if your insurance company covers our treatments, please find out *before* your first appointment so that you will know if an insurance receipt will be necessary.** We **do not** accept insurance. However, we will issue you a receipt ***for you to submit*** to your insurance company for reimbursement **ONLY** if you have your diagnosis code from a Western Medical Doctor. Please be sure to give us your diagnosis code upon your initial appointment. Supporting documentation may be required, including a letter of diagnosis. **Insurance receipts will not be issued retroactively, so please be sure to ask for one upon each visit.** Please inform your insurance company to pay any reimbursement checks directly to you, as we do not interact with your insurance company on your behalf.

**Before each treatment:** Please abstain from alcohol, caffeine and other drugs for 24 hours prior to your appointment. (However, you may take your normal medication, if any). Your stomach should not be empty and not full. If it has been a long time since you have eaten, you should eat a light snack before coming in. **Please do not scrape or brush *your tongue* the evening before or the day of your appointment.**

**Fertility client's first appointment:** When you visit the clinic for your first treatment, bring the results of any Western medical hormone-level tests (FSH/LH) taken ***within three months*** (if available). For your male partner, please bring any information related to ***sperm count or motility***. **NOTE: ALL MALE FERTILITY PATIENTS MUST CALL TO SCHEDULE THEIR OWN APPOINTMENT. ALL NEW PATIENTS WILL RECEIVE ORGAN ACUPRESSURE, MERIDIAN ACUPRESSURE AND ACUPUNCTURE ON THEIR 1ST VISIT.**

**For your first visit:**

- A practitioner will interview you to ascertain your specific concerns and gather pertinent information about your general health from the perspective of Chinese Medicine. You will also receive acupressure from our practitioners, including Chi Organ Acupressure and Chi Meridian Acupressure, as directed by Dr. Wu after she reviews your chart, which may vary with each appointment. Note: There is no pre-treatment consultation, and you will **NOT** see Dr. Wu until **AFTER** your acupressure.
- After you have received your acupressure, you will receive acupuncture from Dr. Wu. If you have any questions, this is the time to ask them so please have your questions as concise as possible. You may also e-mail your list of questions prior to your appointment so that they may be addressed during your visit
- Dr. Wu will usually prescribe herbs for you to take at least until your next visit. She may also strongly recommend avoiding or consuming certain foods. The herbs and eating/drinking recommendations are specific to each person. These will be explained to you after your treatment.

**IVF/IUI (ARTs):** If you are undergoing any **Assisted Reproductive Technologies (ARTs),** such as **In Vitro Fertilization (IVF)** or **Intrauterine Insemination (IUI),** Dr. Wu's Fertility Program can increase the effectiveness of your Western procedure and can reduce the side effects of any drugs and/or hormones prescribed to you.

**Costs:** **Prices shown are per person.** Payment may be made in the form of cash, check, Visa or MasterCard and must be paid at the time services are rendered. Please bring a method of payment to each visit to avoid any unnecessary delays to your treatment.

## FERTILITY PROGRAM AND REPRODUCTIVE ISSUES:

| Treatments | 1st Visit | 2nd – 8th Visit | 9th Visit & after | Acupressure Only |
|---|---|---|---|---|
| Acupuncture (diagnosis included) | $150 | $120 | $105 | |
| Chi Organ Acupressure | $105 | $105 | $105 | $105 |
| Chi Meridian Acupressure | $ 90 | $ 90 | $ 90 | $105 ($90 when with another acupressure) |
| Total cost | $345 | $315 | $300 | |

**Weekly treatments are usually recommended.**

**NOTE: ALL MALE FERTILITY PATIENTS WILL RECEIVE ORGAN ACUPRESSURE, MERIDIAN ACUPRESSURE AND ACUPUNCTURE ON THEIR 1ST VISIT.**

## GENERAL HEALTH AND OTHERS:

| Treatments | 1st Visit | Subsequent Visits | Acupressure Only |
|---|---|---|---|
| Acupuncture (diagnosis included) | $120 | $105 | (as recommended by Dr. Wu) |
| Chi Organ Acupressure | $105 | $105 | $105 |
| Chi Meridian Acupressure | $ 90 | $ 90 | $105 ($90 when with another acupressure) |
| Total cost | $315 | $300 | |

**NOTE: ALL NEW PATIENTS WILL RECEIVE ORGAN ACUPRESSURE, MERIDIAN ACUPRESSURE AND ACUPUNCTURE ON THEIR 1ST VISIT.**

Initial General Health Acupuncture visit**: $120.00,** subsequent Acupuncture visits**: $105.00**. When acupuncture is not received, the Chi Organ Acupressure and Chi Meridian Acupressure are **$105.00** each. Chi Meridian Acupressure is **$90.00** when scheduled with another acupressure. In most cases, the **TOTAL** for the first visit will be **$315.00**.

**HERBS:** Any herbs that are prescribed are an additional cost. Herbs cost an average of $25.00 each per week. Please be aware that you may be prescribed an average of three to six herbs and in some cases more depending on your specific diagnosis.

**PRE-NATAL CLIENTS:** The benefits of Dr. Wu's fertility treatment guidelines, include: less tiredness, increased vitality, fewer emotional outbursts, greater calmness, less nausea, a normal appetite, a tremendous decrease in miscarriages, and full-term pregnancies.

# Dear Clients and Potential Clients of Wu's Healing Center:

**For over thirty years of clinical practice, Dr. Angela C. Wu has questioned long standing beliefs prevalent in Traditional Chinese Medicine and tested new cutting edge approaches, the foremost being needling pregnant women, something traditional acupuncturists, restrained by centuries of tradition, historically did not do. Her pioneering efforts led to the development of a successful and effective fertility program. Dr. Wu discovered that the most important aspects for ensuring a healthy pregnancy are lifestyle changes including changing eating and drinking habits. Her comprehensive fertility treatment program includes eating and drinking guidelines, special herbal formulas, and stress reducing techniques designed to maximize your fertility potential.**

**We would like to remind you that when coming to Wu's Healing Center, you will be treated by Dr. Wu or, in the event of her absence, one of her associates.**

**The associates closely follow a protocol that has been set up by Dr. Wu and they report all cases to her.**

**To wait only to see Dr. Wu may delay the appointment to possibly several weeks, as we are a very busy clinic and appointment slots fill quickly.**

**The Fertility Program consists of several aspects including:**

- **Acupuncture**
- **Acupressure**
- **Nutritional Supplements**
- **Eating & drinking guidelines**
- **Home self-practice**

**Please avoid the use of ALL SCENTED PRODUCTS, such as BATH OILS, ESSENTIAL OILS, INCENSE, CANDLES, SACHETS, LOTIONS, PERFUMES, etc.**

**These could cause <u>severe reactions</u> for our clients.**

**Wu's Healing Center** **1014 Clement Street, San Francisco, CA 94118** **(415) 750-5050**

**PLEASE USE BLUE OR BLACK INK ONLY**

**Last Name:** ________________________ **First Name:** ________________________
**Name You Prefer To Be Called (if different than above):** ________________________
**Sex: (circle one)** **M** **F** **Marital Status:** ____________________**Age:**____________
**Birthdate/ Time/ Place:** ______________/______________/____________________
**Address:** ________________________ **City/State/Zip:** ____________________
**Home Phone:** ______________ **Work:** ________________**Cell:** ______________
**E-mail/Fax:** _______________**Emergency Contact Name & #:** ________________
**How did you hear about us?** ________________ **Your Occupation:** ______________
**Employed by:** ____________________ **Your Dr's Name:** ____________________
**Specialty:** ____________________________**Your Dr's Phone #:** ________________
**Diagnosis by Your Dr:**____________________________________________
**Present Complaints/Reason(s) for visiting our clinic (required):**____________________
____________________________________________________________
____________________________________________________________
**When Developed and How:**____________________________________________
**Treatment Received, If Any:** ____________________ **How Long:** ________________
**Current Height:** ____________________ **Current Weight:** ____________________
**Blood Type (if known):** _______________**Blood Pressure (if known):** ________/________
**Cholesterol (if known) HDL:**____________________**LDL:**____________________

**Please answer the following questions yes or no:**

Do you bruise or discolor easily? ____
Do you bleed for a long time? ____
Do you have high blood pressure? ____
Do you or have you ever had any heart problem? ____
Do you have any respiratory problems? ____
Have you had any surgery before? ____
Are you in therapy at this time? ____
Are you taking any medications? ____

Are you hungry at this time? ____
Are you exhausted at this time? ____
Are you nervous at this time? ____
Are you pregnant at this time? ____
Do you have a compensation claim or lawsuit pending your complaint? ____
Have you had acupuncture before? ____
How does your body respond to soft tissue manual therapy? Circle all that apply: Improvement, Neutral, Sore, Very Sore, Unknown, Other ____________________

I, the undersigned, realize that acupuncture / acupressure may be considered an investigative procedure in the United States of America. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatment. Every attempt will be made to protect me from harm, but there may be the possibility of unfavorable skin reaction, unforeseen nerve damage, possible infection, unexpected bleeding and / or other complications not anticipated. I realize that I may withdraw from the program at any time. **I agree to pay for all services at the time they are received.**

**Patient's Signature:** ________________________ **Date:** ____________________

**Age period began:** ______________________

**Average number of days in your cycle:** ______________________

**Duration of period:** ______________________

**Please check appropriate spaces.**

Pain/Cramps: _____none _____prior to period _____during period _____after period

Intensity of pain/cramps: ______great ______moderate _____light

Color of menstrual blood: _____light _____medium _____dark

Menstrual flow: _____has clots ____is heavy ____is light _____has fishy odor _____has rotten odor

Non-menstrual bleeding/spotting? _____No _____Yes

Water weight gain/bloating: _____prior to period _____during period _____after period

Other physical / emotional changes related to cycle:
______________________________________________________

Please indicate how long you have used any of the following birth control methods:

__________Abstinence __________Pill __________Condom __________Condom with foam or jelly

__________Spermicides __________IUD __________Diaphragm __________Diaphragm with foam or jelly

_____Withdrawal _____Rhythm _____Other: ______________________________________

Vaginal Discharge: ______No ______Yes Color: ___________ Odor: ______________

Vaginal infections: ______Past ______Present How treated:____________________________

**Have you ever been pregnant?** _____No _____Yes Number of times: _____________

Was pregnancy **natural** or with **IVF/IUI**? ________________________________

Number of children living: ____________ Year child was born: (1)_________ (2)_________ (3) _________

Condition of newborns: _____ healthy _____ premature _____ jaundice _____ late _____ other

**Have you ever miscarried?** _____No _____Yes Number of times: ______________

**Have you ever had an abortion?** _____No _____Yes Number of times: ______________

**Reason(s)** ________________________________________________________________________

Other complications related to pregnancy? ____________________________________________________________

Have you gone through menopause? ____Yes ______No If yes, when?______________________________________

Other remarks regarding OB/GYN? ____________________________________________________________

______________________________________________________________________________________________

# Wu's Healing Center 1014 Clement Street, San Francisco, CA 94118

## ***Patient's Symptoms***

Patient's Name:_______________________________________________Date_________________

Please tell us your symptoms and whether they are something you've experienced in the **past** or that you are **presently experiencing**. There are some things that many people have experienced at some point in the past, such as a headache. In this case we'd like to know if this was something that was common for you or that you frequently experienced as opposed to a rare, isolated incident.

**General**

***Past / Present***

( ) ( ) fatigue
( ) ( ) sleep problems
( ) ( ) swollen glands
( ) ( ) hot or cold intolerance
( ) ( ) frequent headaches
( ) ( ) weight loss
( ) ( ) weight gain
( ) ( ) fever or chills
( ) ( ) allergies
( ) ( ) car accident injury
( ) ( ) knocked unconscious

**Nervous System**

( ) ( ) dizziness
( ) ( ) blurred vision
( ) ( ) fainting
( ) ( ) paralysis
( ) ( ) tremors
( ) ( ) numbness / tingling
( ) ( ) convulsion
( ) ( ) imbalance
( ) ( ) memory loss
( ) ( ) muscle weakness

**Urinary**

( ) ( ) painful urination
( ) ( ) frequent urination
( ) ( ) difficulty urinating
( ) ( ) incontinence
( ) ( ) bed wetting
( ) ( ) discolored urine
( ) ( ) frequent infections
( ) ( ) prostate problems
( ) ( ) unusual discharge

**Head**

( ) ( ) headaches
( ) ( ) entire head
( ) ( ) back of head
( ) ( ) forehead
( ) ( ) temples
( ) ( ) migraine
( ) ( ) head feels heavy
( ) ( ) dizziness
( ) ( ) light headedness
( ) ( ) fainting
( ) ( ) light bothers eyes
( ) ( ) loss of smell
( ) ( ) loss of taste
( ) ( ) loss of balance
( ) ( ) loss of hearing
( ) ( ) loss of memory
( ) ( ) pain in ears
( ) ( ) ringing in ears
( ) ( ) buzzing ears
( ) ( ) concussion/head injury

**Neck**

( ) ( ) pain in neck
( ) ( ) neck pain with movement
( ) ( ) pinched nerve in neck
( ) ( ) neck feels out of place
( ) ( ) stiff neck
( ) ( ) muscle spasms in neck
( ) ( ) grinding sound in neck
( ) ( ) popping sounds in neck
( ) ( ) arthritis in neck

**Emotional**

( ) ( ) anxiety or worry
( ) ( ) nervousness
( ) ( ) irritable
( ) ( ) frequent crying
( ) ( ) anger
( ) ( ) tension
( ) ( ) mood swings
( ) ( ) fear
( ) ( ) restlessness
( ) ( ) confusion
( ) ( ) depression
( ) ( ) suicidal

**Reproductive system**

( ) ( ) painful intercourse
( ) ( ) prostate problems
( ) ( ) birth control methods
( ) ( ) sexual problems
( ) ( ) loss of sex drive
( ) ( ) genital infections

**Low back**

( ) ( ) low back pain
( ) ( ) pinched nerve in low back

**Pain is *worse* with:**

( ) ( ) lifting
( ) ( ) stooping
( ) ( ) standing
( ) ( ) sitting
( ) ( ) bending
( ) ( ) coughing

**Back**

( ) ( ) slipped disk
( ) ( ) low back feels out of place
( ) ( ) muscle spasms
( ) ( ) arthritis

**Mid back**

( ) ( ) shoulder blades
( ) ( ) sharp stabbing

**Pain/mid back**

( ) ( ) chest pain
( ) ( ) sharpness of breath
( ) ( ) pain around ribs

**Ear/ eye/ nose/ throat**

( ) ( ) earache
( ) ( ) ear discharge
( ) ( ) ringing in ears
( ) ( ) hearing loss
( ) ( ) nose bleeds
( ) ( ) hoarseness
( ) ( ) problems swallowing
( ) ( ) sore throats
( ) ( ) jaw tight or sore
( ) ( ) dental problems
( ) ( ) sinusitis
( ) ( ) tonsillitis

**Musculoskeletal**

( ) ( ) joint swelling
( ) ( ) muscle cramps
( ) ( ) shoulder pain
( ) ( ) tennis elbow
( ) ( ) arm pain
( ) ( ) hand sensations
( ) ( ) loss of grip
( ) ( ) mid back pain
( ) ( ) rib pain
( ) ( ) low back problems
( ) ( ) hip pains
( ) ( ) foot problems
( ) ( ) leg cramps
( ) ( ) knee pain
( ) ( ) ankle weakness
( ) ( ) tingling foot

**Shoulders**

( ) ( ) pain in shoulder joint
( ) ( ) pain across shoulders
( ) ( ) bursitis
( ) ( ) arthritis
( ) ( ) can't raise arm above shoulder
( ) ( ) over head
( ) ( ) tension in shoulders
( ) ( ) pinched nerve in shoulder
( ) ( ) muscle spasms in shoulders

**Arms and hands**

( ) ( ) pain in upper arm
( ) ( ) pain in forearm
( ) ( ) pain on hands
( ) ( ) pain in fingers
( ) ( ) pinched nerve in arm
( ) ( ) pins and needles in arms
( ) ( ) pins and needles in fingers
( ) ( ) fingers go to sleep
( ) ( ) hands cold
( ) ( ) pain in finger joints
( ) ( ) arthritis in fingers
( ) ( ) loss of grip strength

**Heart/Lung**

***Past / Present***

( ) ( ) chest pain
( ) ( ) high blood pressure
( ) ( ) low blood pressure
( ) ( ) persistent cough
( ) ( ) hard to breathe
( ) ( ) coughing blood
( ) ( ) coughing phlegm
( ) ( ) irregular heartbeat
( ) ( ) varicose veins
( ) ( ) ankle swelling
( ) ( ) heart disease
( ) ( ) heart attack

**Gastrointestinal**

( ) ( ) change in appetite
( ) ( ) thirst
( ) ( ) nausea
( ) ( ) vomiting
( ) ( ) diarrhea
( ) ( ) constipation
( ) ( ) gas
( ) ( ) hemorrhoids
( ) ( ) gall bladder
( ) ( ) belching
( ) ( ) heart burn
( ) ( ) abdominal pain
( ) ( ) bloody black stools
( ) ( ) indigestion
( ) ( ) liver trouble

**Skin**

( ) ( ) easy bruising
( ) ( ) dry skin
( ) ( ) itching
( ) ( ) boils
( ) ( ) rashes
( ) ( ) excessive sweat
( ) ( ) hair changes

**Hips, legs and feet**

( ) ( ) pain in buttocks
( ) ( ) pain in hip joint
( ) ( ) pain down in legs
( ) ( ) pain down both legs
( ) ( ) leg cramps
( ) ( ) pins and needles in hands
( ) ( ) numbness of leg
( ) ( ) numbness of hands
( ) ( ) numbness of toes
( ) ( ) feet feel cold
( ) ( ) cramps in feet
( ) ( ) swollen ankles
( ) ( ) painful joints in toes
( ) ( ) pain in feet

**Disease**

( ) ( ) diabetes
( ) ( ) gout
( ) ( ) emphysema
( ) ( ) bronchitis
( ) ( ) stomach ulcer
( ) ( ) duodenal ulcer
( ) ( ) gall bladder disease

**Disease (cont.)**

( ) ( ) kidney stones
( ) ( ) kidney infection
( ) ( ) bladder infection
( ) ( ) sclerosis
( ) ( ) tuberculosis
( ) ( ) cancer
( ) ( ) goiter
( ) ( ) epilepsy
( ) ( ) nervous breakdown
( ) ( ) hepatitis A
( ) ( ) hepatitis B
( ) ( ) hepatitis C
( ) ( ) HIV infection
( ) ( ) gonorrhea
( ) ( ) syphilis
( ) ( ) anemia
( ) ( ) mumps
( ) ( ) rheumatic fever
( ) ( ) German measles
( ) ( ) chicken pox

**Yes / No**

( ) ( ) any other diseases?

______________________________

( ) ( ) any communicable diseases?

______________________________

**Allergies**

**Yes / No**

( ) ( ) moxa (mugwort)
( ) ( ) mint
( ) ( ) latex
( ) ( ) pollen
( ) ( ) fungus / mold
( ) ( ) wheat / gluten
( ) ( ) dairy
( ) ( ) egg
( ) ( ) wheat
( ) ( ) shellfish

**Please list any other allergies.**
(outdoor allergens, food, medications)

______________________________
______________________________
______________________________
______________________________

**Surgical history**

**Yes / No**

( ) ( ) tonsillectomy
( ) ( ) appendix
( ) ( ) hernia operation
( ) ( ) hemorrhoid operation
( ) ( ) stomach operation
( ) ( ) gall bladder operation
( ) ( ) varicose vein operation
( ) ( ) thyroid operation
( ) ( ) prostate operation
( ) ( ) cesarean section
( ) ( ) removal of ovaries
( ) ( ) other

______________________________
______________________________

**Do you take medication regularly?**

If so, what?

______________________________
______________________________
______________________________
______________________________
______________________________
______________________________

**Have you ever taken?**

( ) ( ) insulin
( ) ( ) cortisone
( ) ( ) thyroid medicine
( ) ( ) male/female hormones
( ) ( ) tranquilizers/sedatives
( ) ( ) birth control pills

**Others?**

______________________________
______________________________
______________________________
______________________________

**Have you had x-rays of?**

( ) ( ) chest
( ) ( ) stomach
( ) ( ) gall bladder
( ) ( ) kidneys
( ) ( ) skull
( ) ( ) colon
( ) ( ) ____________________

**What kinds of supplements are you taking now?**

______________________________
______________________________
______________________________
______________________________

**Please list any other information you feel is important for us to know in regard to your health.** (Please include your ***family history*** of medical issues such as heart attack, thyroid condition, cancer, etc.)

______________________________
______________________________
______________________________
______________________________
______________________________
______________________________
______________________________
______________________________

**Wu's Healing Center** **1014 Clement Street, San Francisco, CA 94118** **(415) 750-5050**

**Dear Clients:**
**In order to provide quality care to all of our clients, we have established the following policies. Please read carefully, as you are agreeing to follow these policies as a critical part of your participation with our clinic. If you have any questions, please ask our staff before signing.**

1. **Our cancellation policy is designed to honor your time as well as ours.** Please be sure to notify us ***at least 48 hours in advance*** when canceling your appointment. For example, if you have a 3 p.m. appointment on Wednesday, you need to cancel by 3 p.m. on Monday. However, because we are open only on Monday, Wednesday and Friday, if you have a 9 a.m. Monday appointment, *you will need to call by 9 a.m. the previous Friday to cancel.*
   - **A. We schedule our staff based on your appointment with us. In the event of a cancellation within 48 hours of your appointment, you will be charged the full cost of your scheduled treatment.**
   - **B. In the event of a no-show, you will be charged the full cost of your scheduled treatment.**
   - **C. We also ask that you provide *48 hours notice if you wish to shorten the length of your appointment* – for example, changing from a 2-hour treatment to a 1-hour treatment. Without 48 hours notice, you will be charged the full cost of the original appointment.**

2. **Please arrive on time for your appointment.** If you are late, you will have to wait to be seen until after those clients who have arrived on time, which may result in a delay of up to 1 hour or longer.

3. The unpredictability and urgency of IVF schedules may need an intensified treatment regime. As a result, the schedule may be backed up without prior notice. Please schedule your appointments accordingly. **Your patience and understanding is appreciated.**

4. **Herbs, books and all other products are non-refundable and non-returnable.** Please keep this in mind when purchasing your herbs, as your herb prescription may change during your next visit. We do not mail herbs, so please order enough to last until your next visit, especially if you live outside of San Francisco.

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Thank you for your support and cooperation.
We hope that these policies help us to create a positive and
beneficial experience for you each time that you visit our office.

# Patient Copy

# Please keep this copy for your records.

# Wu's Healing Center

1014 Clement Street, San Francisco, CA 94118 (415) 750-5050

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Thank you for your support and cooperation.
We hope that these policies help us to create a positive and
beneficial experience for you each time that you visit our office.

**I understand that my signature acknowledges that I have read and agree to follow the above policies.**

**Signature: ________________________________Date:____________________**

**Clinic Copy**

Wu's Healing Center 1014 Clement Street, San Francisco, CA 94118 (415) 750-5050

# PATIENT INFORMATION AND STATISTICS CONSENT FORM

I, ______________________________________ (print your name) authorize Wu's Healing Center and members of its Medical Clinic Staff, faculty and students to review my records for the purpose of collecting statistical data or pertinent clinical information for the purposes of research, publication, education and case study review. I give permission and consent to the publication of statistical and/or clinical data obtained from my records. I understand that all patient records are protected by clinic protocols and confidentiality agreements. **I also understand that I will never be identified as the source of this information and that if any particulars of my case are used for the purposes of publication all possible clues to my identity will be disguised or altered unless I so authorize.**

If you ACCEPT the use of your information as described above, please sign below:

**I ACCEPT:** ______________________________ ______________________

**Patient Signature** **Date Signed**

If you DECLINE the use of your information as described above, please sign below:
(Please do not print your name in the above paragraph if you choose this option)

**I DECLINE:** ______________________________ ______________________

**Patient Signature** **Date Signed**