Ni's Chinese Medical Center

COLD/FLU HERB PROGRAM

SYMPTOMS

Please check all boxes that apply.

☐ **NO SYMPTOMS**

I would like immune boosting herbs

- ☐ Fever
- ☐ Chills
- ☐ Hot & Cold flashes
- ☐ Feel hot all the time
- ☐ Feel cold all the time
- ☐ Sweating
- ☐ No Sweating

- ☐ Body aches
- ☐ Headache
- ☐ Stiff neck
- ☐ Chest ache

- ☐ Congestion If so, what part of body? _____
- ☐ Hard time breathing or heavy chest
- ☐ Mucus if so, what color?
  - ☐ White
  - ☐ Yellow
  - ☐ Green
  - ☐ Clear
- ☐ Sneezing
- ☐ Cough
- ☐ Sore throat

- ☐ Dizzy
- ☐ Nauseated
- ☐ Vomitting
- ☐ Loss of appetite

How many bowel movements do you have each day? _____

Additional Symptoms not listed:

_____

_____

_____

_____

PATIENT INFORMATION

PLEASE PRINT CLEARLY.

NAME: _____

SHIPPING ADDRESS: _____

(NO P.O. BOXES) CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ PHONE: _____

EMAIL: _____

PAYMENT AUTHORIZATION

I authorize Bo-Shih Ni, C.A., P.A. d/b/a Ni's Chinese Medical Center to keep my signature on file and to charge my credit card account as indicated below for each recurring treatment.

I understand that this form is valid for one year unless I cancel the authorization through written notice to the healthcare provider.

Type of card: (MC, Visa, Discover) _____

_____

Patient Name

_____

Cardholder Name

_____

Cardholder Billing Street Address

_____

City *State* *Zip*

_____

Card Number

_____ _____

Expiration Date *3-digit CSC*

_____

Cardholder Signature *Date*

PHOTO ID MUST ACCOMPANY THIS FORM.

Please send photo ID as an attachment in your email with this form.

Thank you!

INFORMED CONSENT FOR TREATMENT

PLEASE READ BEFORE SIGNING

I hereby request and consent to be treated with Chinese herbal medicine by Bo-Shih Ni who is a Licensed and Board Certified Acupuncturist in the state of Florida.

I understand that the herbs may need to be prepared and consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I accept the fact that **no guarantee** is made concerning the outcome of my treatments with herbal medicine. I accept the fact that each combination of herbs is designed for my needs and my needs only, ***and*** **therefore I cannot receive a refund on any herbs or any services rendered**. I also understand that I may stop treatment at any time.

I have the right to refuse treatment; however, I must communicate this to the clinical staff **before** any herbal prescription has been filled for me; otherwise I will be obligated to pay for the herbs prescribed.

I will notify the physician if I am or become pregnant.

By signing below I show that I have read, or have had read to me, this consent to treatment, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Name _____

Patient's Signature _____

Date

To be completed by the patient's Guardian if the patient is a minor or is physically or legally incapacitated. The person who is given Power of Attorney over the patient, must sign these documents, be present at all appointments and must provide a copy of the Power of Attorney.

Print Name of Patient Guardian_____

Signature of Patient Guardian_____

Relationship or Authority of Patient_____

Payment must be made in full when service is rendered.

We accept Mastercard, Visa, and Discover

3/2020