



Cayman Physiotherapy Ltd.

West Shore Center, 508 West Bay Road.
World Gym, Queens Court, 1 Snooze Lane.
P.O. Box 31014, Grand Cayman, KY1-1205
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Email: caymanphysio@gmail.com
www.caymanphysio.com

Acu Intake - **PLEASE PRINT CLEARLY**

First name _____

Gender ☐ M ☐ F DOB DD / MM / YYYY

Preferred name _____

Mobile _____

Middle initial _____

Work _____

Last name(s) _____

Email _____

Street address _____

Emergency contact _____

District _____

Mobile _____

P.O. Box _____ Post Code _____

Email _____

Insurance Information – Primary Insurance

Insurance company _____ Member ID/Certificate no. _____

Group/Policy no. _____ Company name (under which policy is registered) _____

I, the undersigned certify that I (or my dependent) have insurance coverage with _____, and assign directly to Cayman Physiotherapy Ltd. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the clinic to release all information necessary to secure the payment of benefits.

Cancellations, no shows and late arrivals policy

In consideration of your therapist and other patients, Cayman Physiotherapy Ltd. kindly asks that you notify us at least 4 hours prior to your scheduled appointment if you will be unable to keep your appointment. This will allow the opportunity to fill the space with another patient. Failure to do so may result in an **\$80.00 CI No Show fee**. Late arrivals compromise the efficacy of treatment for you and the next patient. Patients arriving more than 15 minutes late may need to be rescheduled.

I have read, understand, and agree to the above policy of Cayman Physiotherapy Ltd.

Signed _____ Date DD / MM / YYYY

Signed by parent or guardian if patient is a minor _____

****PLEASE TURN OVER****

Informed Consent to Acupuncture Treatment

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture as necessary, including moxibustion, cupping, and/or electroacupuncture by any authorized acupuncturist at Cayman Physiotherapy.

I also understand that at any time I feel pain or discomfort during the session, I will immediately inform my practitioner. I have stated my pertinent medical conditions, and will update the practitioner of any changes in my health status.

I have been informed that in all acupuncture treatments, only sterile, disposable needles are used to ensure the safest acupuncture treatment possible. I fully understand that in the case of pregnancy, the risk of causing fetal distress with acupuncture treatment(s) is possible.

I have been informed that acupuncture is a safe method of treatment but may have some side effects, including but not limited to bruising, numbness or tingling, dizziness or fainting, minor swelling, and/or bleeding. A hematoma may occur at the site of insertion and may last a few days. A sensation of light-headedness may occur after acupuncture treatment. I will immediately notify the acupuncturist if I experience any symptoms or problems. I understand that I should not make significant movements while the needles are being inserted, manipulated, retained, or removed. I understand that on rare occasions moxibustion therapy may result in a burn at the site of application. I understand that I should not make significant movements while moxibustion is being applied. I will immediately inform the acupuncturist if the moxibustion feels at all uncomfortable.

I am relying on the practitioner to exercise judgment and caution during the course of my treatment, trusting that, based upon facts then known, this treatment plan is appropriate and in my best interests. I understand that acupuncture and other Chinese and Japanese Medicine procedures are not substitutes for treatment by my medical doctor. Also, at any given time throughout the treatment, I may request the practitioner to stop, modify, or change the treatment plan.

This is NOT a waiver form. It is part of our "duty of care" to you that we inform you of any material (pertinent) risks associated with professional treatment techniques. In very rare cases, acupuncture has been reported as being associated with bodily infections or collapse of a lung. Allergic skin reactions to massage oils, acupuncture needles, or topical applications are a possibility.

I will inform my practitioners immediately of any discomfort with this arrangement and steps will be taken to modify my treatment. By voluntarily signing below, I hereby certify that I have read this entire form, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I consent to treatment with the modalities described above. I intend this consent form to cover the entire course of treatment to be performed for my present condition. I have read this form, understand the information it contains, and give my consent to treatment.

Signed _____ Date DD / MM / YYYY

Signed by parent or guardian if patient is a minor _____