

San Antonio Health Acupuncture  
San Antonio, TX 78232

I (patient's name) \_\_\_\_\_ am notifying the San Antonio Health Acupuncture, LLC of the following.

\_\_\_\_\_ Yes \_\_\_\_\_ No I have been *evaluated* by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed.

I recognize that I should be evaluated by a physician for the condition being treated by the acupuncturist

Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ Yes \_\_\_\_\_ No I have received referral from my chiropractor within the last 30 days for acupuncture.

After being referred by a chiropractor, if after 120 days or 30 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice to follow the advice.

Signature \_\_\_\_\_ Date \_\_\_\_\_