MARIN L. KOKIN, L.Ac.
KOKIN HEALING CENTER
23603 Park Sorrento, Suite 101
Calabasas, CA 91302
Phone 818.456.4393 Fax 818.456.4345

Dear New Patient:

Please find attached the **patient information packet**.

We look forward to seeing you at our Calabasas office.

We are located at 23603 Park Sorrento, Suite 101. The nearest cross street is Park Granada. There is *complimentary* valet parking in the Park Sorrento lot and the office is just through the archway on the right.

Directions:

From the East/Los Angeles, exit 101 West at Valley Circle Blvd. and make a LEFT. Make a RIGHT on Calabasas Road. Left on Park Granada. LEFT on Park Sorrento. Parking lot entrance is on your immediate LEFT.

From the West/Agoura, exit 101 East at Parkway Calabasas, and immediate LEFT onto Calabasas Road. Make a RIGHT on Park Granada. LEFT on Park Sorrento. Parking lot entrance is on your immediate LEFT.

Please remember to bring your paperwork and wear loose clothing.

We look forward to meeting you!

If you have any questions, please feel free to call (818) 456-4393.

Please call 24 hours in advance to reschedule or cancel your appointment.

PATIENT REGISTRATION

WELCOME TO OUR OFFICE! PLEASE DO NOT HESITATE TO ASK US ANY QUESTIONS!

Date: _____ E-Mail: _____

Patient:_____
Last Name First Name MI

Street Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Cell Phone Carrier:_____

Birth Date:_____ Age:_____ Sex: Male / Female # of children:_____

Marital Status (please circle): Single Married Divorced Separated Widow

Social Security:_____ I.D. / Driver's License:_____

Employed: Full Time Part Time Retired None Student: Full Time Part Time

Emergency Contact Name: _____ Relation: _____

Emergency Phone: _____

Whom may we thank for the referral? _____

Patient Signature: _____

INSURANCE INFORMATION

Relationship to Insured: Self Spouse Child Other / Describe_____
Insured's Name:_____
Last Name First Name MI
Birth Date:_____ Age:_____ SSN#:_____Sex: Male / Female
Employer Name: _____
Employer Address:_____
Insurance Company:_____
Address:_____
Phone:_____
ID#:_____
Is your condition related to employment (past or current) Yes No Worker's Comp? Yes No
Is your condition related to an auto accident/personal injury? Yes No

If you've answered "yes" to one of the above, please ask for work comp/personal injury form.

PATIENT CONDITION

Patient Name:_____ **Date:**_____

Reason for visit: _____

_____

_____

Have you seen any other doctor about this condition? _____ If yes, when? _____
Doctor's name**:**_____
Doctor's phone number**:** _____ Address? _____

When was your last medical examination?_____
Who is your regular doctor?_____
Doctor's phone number: _____ Address? _____

Please answer the following: (please circle your answer)

Females: Are you pregnant?	Yes	No	Due Date: _____
Are you hungry?	Yes	No	
Are you HIV positive?	Yes	No	
Do you have hepatitis?	Yes	No	
Do you have a pacemaker?	Yes	No	

List any prescribed medication that you are presently taking:

MEDICATION	DOSAGE	REASON
1.		
2.		
3.		
4.		

What vitamins, herbs, and/or supplements do you regularly take?

MEDICATION	DOSAGE	REASON
1.		
2.		
3.		
4.		

FOR MINORS: List both Parents' Names, Addresses and Phone Numbers (work, home and cell)
Mother: _____
Father: _____

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CANCELLATION POLICY

Due to excessive "cancellations and "no-shows", I am left with no choice but to reinstate my 24 hour cancellation policy. We have reserved the time and room to accommodate your schedule. If you are unable to keep your appointment, it is your responsibility to provide me 24 hours notice.

IF LESS THAN 24 HOURS IS GIVEN A FEE OF $85.00 FOR ACUPUNCTURE / $95.00 FOR MASSAGE WILL BE YOUR FINANCIAL LIABILITY. PLEASE KEEP IN MIND THAT YOUR INSURANCE COMPANY DOES NOT COVER THIS FEE.

I understand an emergency may arise from time to time, preventing you from keeping your appointment. Re-scheduling your appointment in a timely manner may avoid such fee.

I have read and understood the policy. I am aware that I will be personally responsible for any cancellation fees. I feel this is a fair policy for everyone in need of acupuncture / massage treatment.

_____ _____

Date **Patient Signature**

_____

Patient Name (print)

AUTHORIZATION FORM

I hereby authorize Dr. MARIN L. KOKIN, L.Ac. to furnish information to my insurance carriers concerning my illness and treatments.

Please print the doctor's full name and check "Yes" or "No" to indicate which type of release you authorize:

1. I authorize a complete medical records/billing release for all dates of treatment. ☐ Yes ☐ No

2. I authorize Dr. MARIN L. KOKIN, L.Ac. to release only the specific dates, medical record/billing records necessary to furnish information needed by my insurance carrier to make a determination. ☐ Yes ☐ No

3. I authorize Dr. MARIN L. KOKIN, L.Ac. to release information upon my request/verification via fax. This release is specific to the patient's request. ☐ Yes ☐ No

4. I authorize Dr. MARIN L. KOKIN, L.Ac. to release information on my telephone answering machine. This information usually relates to reminders of medical appointments, call medical office back, medical information requested by the patient such as medication refills, normal results and other customary reporting. Confidential results or sensitive issues will not be left on telephone answering machines. ☐ Yes ☐ No

Patient Signature (required) Date (required)

I assign to the doctor/medical group the option to bill my insurance carrier(s) directly for any/all payments for services rendered to me or to my dependents. I understand that I am responsible for all amounts for services rendered.

Patient Signature (required) Date (required)

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas 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 have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, 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.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative)

(Indicate relationship if signing for patient)