Lake Internal Medicine Associates
Steven M. Tang, M.D.
2101 Prevatt Street
Eustis, FL 32726
(352) 589-4774

CONSENT FORM FOR ACUPUNCTURE

I agree to a therapeutic trial of acupuncture for my condition. My physician acupuncturist has discussed with me the potential risks and benefits. Possible risks which I accept include but are not limited to those related to infection, bleeding, lung puncture, other organ puncture, and nerve damage, including spinal cord trauma, local bleeding or swelling. I recognize that significant sickness or even death could occur as a remote but real possibility of this therapy which places needles through the skin and uses either manual or electrical stimulation.

Contra-indications for acupuncture include history of bleeding disorder or current anticoagulant therapy, implanted pacemaker or prosthetic valve or pregnancy. I will inform my physician acupuncturist if any of these conditions exist.

I am also aware that acupuncture may mask an underlying condition or retard a more exact diagnosis where alternative therapy may be known to be indicated.

Certain medications or social habits are known to lessen the potential results of acupuncture and these include alcohol, tobacco, steroids, or narcotics. I have informed my physician acupuncturist of any substances included in this list.

I understand the hazards and potential dangers involved in treatment by means of acupuncture. The nature and consequences of the treatment has been fully explained and no guarantee of results has been made.

I have read and understand the foregoing.

_____ _____

Patient's Signature Date

_____ _____

Witness Signature Date

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MEDICARE MEDICAL NECESSITY FORM

Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. I believe that, in your case, Medicare is likely to deny payment for acupuncture because acupuncture is not a service for which Medicare provides coverage.

I have been notified by my physician that, in my case, Medicare will deny payment for services identified above, for the reasons stated. I agree to be personally and fully responsible for payment.

_____ _____

Medicare Beneficiary Signature Date

PLEASE COMPLETE ALL QUESTIONS. PLEASE **PRINT**.

NAME: _____ DATE: _____

FLORIDA ADDRESS: _____

CITY: _____ ZIP CODE: _____ PHONE: _____

NORTHERN ADDRESS: _____

CITY: _____ STATE: _____ ZIP:_____ PHONE: _____

DATE OF BIRTH: _____ MARITAL STATUS: _____
MEDICARE #: _____SOCIAL SECURITY #:_____

EMPLOYER NAME AND ADDRESS: _____
EMPLOYER PHONE: _____ DO YOU HAVE INSC. WITH THEM?___

PARTY RESPONSIBLE FOR PAYMENT: _____
RELATIONSHIP TO YOU: _____

IN CASE OF EMERGENCY PLEASE NOTIFY (THIS PERSON SHOULD NOT LIVE WITH YOU!!!):
NAME: _____ RELATIONSHIP TO YOU: _____

FULL ADDRESS: _____

PHONE NUMBER: WORK: _____ HOME: _____

YOU MUST BRING THE FOLLOWING ITEMS TO YOUR FIRST OFFICE VISIT:

1. All medication that you are taking. Please bring them in their appropriate bottles.
2. If you have a living will please bring a copy of this to discuss with the doctor.
3. All insurance cards will be copied. Please be sure that all insurance cards other than Medicare clearly list your policy number and address to send claims to. If your card does not give this information please bring this with you.