



# A TOUCH *of* THERAPY

## **Notification Form Regarding Evaluation of Patient by Physician**

*In the state of Texas, acupuncture and Oriental medicine is not considered "primary health care". As a result, A Touch of Therapy is required to have you respond to the following statements before you may be treated. Please be advised that we will not be permitted to treat you with acupuncture if your response to all of these statements is no.*

(Pursuant to the requirement of section 183.6 (e) of this title and section 6.11, Subsection (d) V.A.C.S. article 4495b, governing the practice of acupuncture)

I (patient name), \_\_\_\_\_ am  
notifying A Touch of Therapy of the following:

Yes  No I have been evaluated by a physician or dentist for the condition being treated within twelve (12) months before the acupuncture was performed. I recognize that a physician should evaluate me for the condition being treated by the acupuncturist.

**OR**

Yes  No I have received a referral from a chiropractor within the last 30 days for acupuncture. The date of the referral is \_\_\_\_\_, and the most recent date of chiropractic treatment prior to acupuncture treatment is \_\_\_\_\_. After being referred by a chiropractor, if after 60 days or 20 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 this advice.

**OR**

I have not been evaluated by a physician or dentist for the condition being treated, nor have I received a referral from a chiropractor, but I seek treatment for one of the following conditions:

- Chronic Pain
- Weight Loss
- Smoking Cessation
- Alcoholism
- Substance Abuse

\_\_\_\_\_  
Patient signature (required)

\_\_\_\_\_  
Date