Please be advised of the policies for this office. Your signature on page 2 signifies acceptance of these policies.

COMMUNICATION/APPOINTMENT REMINDERS

The preferred method(s) of communication completed and signature on page 2 authorizes the office staff/practitioner(s) to notify you regarding your appointments or for other communications/information related to the office.

Text (mobile number): _____

Email: _____

Telephone: ☐same as mobile ☐_____

Type: ☐home ☐work ☐_____

Postal Mail: ☐same as on registration ☐_____

CANCELLATION

A 24-hour notice is required for cancellation of an appointment, or you may be charged a cancellation fee for the appointment. Payment is due before your next appointment.

We do not bill insurance companies for missed appointments or late cancellations. You are responsible for paying the missed appointment/late cancellation fees.

TARDINESS

Appointment times are as scheduled and cannot extend beyond the stated time to accommodate late arrivals. Please be on time to your appointment.

SICKNESS

Bodywork is not appropriate care for infectious or contagious illness. Please cancel your appointment as soon as you are aware of an infectious or contagious condition. If it is within the 24-hour notice period, the cancellation fee may be waived.

FINANCIAL RESPONSIBILITY

Payment is required in full for services rendered at the time of visit, unless other arrangements have been made. If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and other expenses incurred in collecting on the practitioner(s) account.

Once your insurance is verified, we will bill and accept payment from your insurance company for covered services. In the event that the insurance company denies payment or makes partial payment, you are responsible for the balance, deductibles, and co-pays. Your signature on page 2 confirms your financial responsibility for all services regardless of insurance reimbursement.

ASSIGNMENT OF BENEFITS

Your signature on page 2 authorizes and directs payment of medical benefits to the practitioner(s) for services provided by this office.

RELEASE OF MEDICAL RECORDS

Your signature on page 2 authorizes the release of all of your/your child/dependents medical records on file in this office, for the purpose of processing claims, to the following: your attorney, the healthcare providers attending to this condition, and the insurance case managers. Medical records will not be edited unless otherwise stated in an exclusive release of medical records signed through your attorney.

ACUPUNCTURE TERMS OF ACCEPTANCE

When a client seeks acupuncture health care and the practitioner accepts a patient for such care, it is essential for both to be working toward the same objectives.

TURN OVER

Name: _____ DOB: _____ Sex: _____ DOS: _____

Name: DOB: Sex: DOS:

Acupuncture is focused upon a few goals: to detect and correct the quality, quantity and balance of Qi, Blood and other body fluids. When done correctly, the body will have the capacity to obtain and maintain health and well-being.

It is important that each client understand the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Acupoint stimulation: The insertion of sterile acupuncture needles cause a specific stimulation of an acupoint. This will facilitate the normal and balanced flow of Qi through the Meridian pathways.

Health: A state of optimal physical, mental and spiritual well-being, not merely the absence of infirmity.

Qi Imbalance: When the quality, quantity and balance of Qi is disrupted, it causes illness and disease. An imbalance in any of the 14 main meridian channels causes an alteration in the flow of Qi through the entire body. This can result in a lessening of the body's innate ability to heal itself and express maximum health potential.

Acupuncture does not offer to diagnose or treat any disease or condition other than the quality, quantity and balance of Qi. However, if during the course of an acupuncture examination the practitioner encounter non-acupuncture or unusual findings, they will advise you. If you desire advice, diagnosis or treatments of those findings, it will be recommended you seek the services of a health care provider qualified to treat those problems.

Regardless of what a disease is called, the practitioner does not offer to treat it. Nor will they offer advice regarding treatment prescribed by others. The ONLY practice objective is to detect and correct imbalances within Meridian pathways using Acupuncture and Chinese medical techniques. This can help facilitate healing and potentially lead to full expression of your body's innate wisdom.

I have read and fully understand the above statements. All questions regarding the Acupuncturist's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept acupuncture care on this basis. My signature below authorizes said acceptance.

MASSAGE THERAPY CONSENT/AGREEMENT

I understand that massage therapy:

- does not diagnose illness or disease, or any other disorder, and that the massage therapist does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of massage therapy.
- is not a substitute for medical examinations or medical care, and that it is recommended that I am concurrently working with my physician, chiropractor or other qualified medical specialist for any condition I may have.

I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments.

Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there will be no liability on the part of the therapist should I fail to do so.

I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

It is my choice to receive massage therapy. I am aware of the risks and benefits of massage and give my consent for massage for myself or my child/dependent. My signature below authorizes said consent/agreement.

AUTHORIZING SIGNATURE

Date _____ Patient/Client/Parent/Guardian *SIGNATURE* _____

Rev. 01/02/2015