

Please initial each box to signify understanding & agreement.

I understand that full payment is expected at the time of service, unless prior arrangements have been made. Payment may be in the form of cash, check, or card. The fee for returned checks is \$40. In the event of insurance reimbursement, I am still expected to pay my portion at the time of service.

I agree to provide at least 24 hours notice by telephone in the event that I need to reschedule or cancel an appointment. I understand that the time is set aside for me, and that if I fail to provide 24 hours notice that I am accountable for the cost of the session.

Privacy Policy

By voluntarily signing below, I show that I have read or have had read to me, the Notice of Privacy Practices, and have had an opportunity to ask any questions.

Printed Name of Patient

Patient Signature

Date

Printed Name & Signature of Legal Guardian (if applicable)

Disclosure & Consent

By voluntarily signing below, I show that I have read or have had read to me, the Disclosure & Consent to Chinese Medical Treatment and Care, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask any questions. By signing below, I consent to the treatment plan. I intend this consent to cover the entire course of my treatment, regardless of which condition is being primarily addressed.

Printed Name of Patient

Patient Signature

Date

Printed Name & Signature of Legal Guardian (if applicable)

Insurance Patients Only

Consent for Release of Information & Direct Payment

I hereby authorize Whidbey Acupuncture + Herbs to release the appropriate health information to my insurance company as it pertains to filing claims. I understand that my authorization will remain effective from the date of my signature until otherwise revoked, and that the information will be handled confidentially in compliance with all applicable federal laws. I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written, dated communication. I also authorize Whidbey Acupuncture + Herbs to receive payment directly from my insurance company.

Printed Name of Insured

Insured Signature