SLO Acupuncture & Integrative Medicine

Thank you for choosing SLO Acupuncture & Integrative Medicine as your care provider. We are committed to providing you with quality care. We have developed this payment policy because some of our patients have had questions regarding patient and insurance responsibility for services rendered. Please read it, and ask us any questions you may have. A copy will be provided to you upon request.

1. Insurance. We participate in some insurance plans. Payment in full is expected at each visit if you are not insured by a plan with which we do business. If you are insured by a plan with which we do business but don't have an up-to-date insurance card, then payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

3. Non-covered services. Please be aware that some or all of the services you receive might not be covered or not considered reasonable or necessary. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the licensed acupuncturist. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. This is done for your protection. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative care.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within 24 hours. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

Patient:_____ _____ _____

Print | Signature of Patient or Responsible Party | Date

Acupuncturist:_____ _____ _____

Print | Signature of Acupuncturist | Date

I. Patient Advisory to Consult a Physician

SLO Acupuncture & Integrative Medicine (SLO Acupuncture) is committed to your health and well-being. While Oriental medicine has a great deal to offer as health care system, it cannot totally replace the resources available through biomedical physicians. Consequently, it is recommended that you consult a physician regarding any condition or conditions for which you are seeking acupuncture treatment.

I undersigned, do affirm that I have been advised by SLO Acupuncture to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

II. Informed Consent to Acupuncture Treatment

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 Therese Powers, L.Ac., and/or other licensed acupuncturist who now or in the future treat me while employed by, working or associated with or serving as back-up for SLO Acupuncture, 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, guasha, electrical stimulation, Tui-Na (Chinese bodywork), 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 have an unpleasant smell or taste. I will immediately notify SLO Acupuncture 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 and guasha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although SLO Acupuncture 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, and hives.

I will notify a SLO Acupuncture who is caring for me if I am or become pregnant.

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

I understand all of my records will be kept confidential and will not be released to any party without my written consent, in full compliance of HIPAA regulations. **My signature below indicates that a written copy of SLO Acupuncture Notice of Privacy Practices was provided to me.** I have also been informed that if I require additional information about this notice I may call SLO Acupuncture.

BY VOLUNTARILY SIGNING BELOW I SHOW THAT I HAVE READ, OR HAVE READ TO ME, THIS CONSENT TO ALL PROCEDURES, 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 MY VISITS FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) DURING MY VISITS TO SLO ACUPUNCTURE & INTEGRATIVE MEDICINE.

Patient:_____ _____ _____

Print | Signature of Patient or Responsible Party | Date

Acupuncturist:_____ _____ _____

Print | Signature of Acupuncturist | Date

ARBITRATION AGREEMENT

ARTICLE 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as state and federal law have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

ARTICLE 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating treatment or services provided the health-care provider including any heirs or past, present or future spouse (s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any staff who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health-care provider, including those working at the health-care provider's office or during outcalls whether signatories to this form or not.

ARTICLE 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and, a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counseling fees, witness fees, or other expenses incurred by a party for such party's benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration and any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this arbitration agreement.

ARTICLE 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statue of the limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

ARTICLE 5: Revocation: This agreement may be revoked by written notice delivered to the health-care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

ARTICLE 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as the date of first professional services.

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have a right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy:

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE **X** **(DATE)**

(Or Patient Representative) (Indicate relationship if signing for patient)

OFFICE SIGNATURE **X** **(DATE)**

This is a CONFIDENTIAL questionnaire to help us determine the best treatment the best treatment plan for you. If you have questions, please ask. Thank you.

PERSONAL INFORMATION

Last Name _____ First Name _____

Date of Birth (MM/DD/YY) _____ Height _____ Weight _____ Gender _____

Home Address _____

City _____ State _____ Zip _____

Contact Phone Number (_____)_____ Email _____

Occupation_____

Emergency Contact: Name _____ Phone (_____)_____

Marital Status _____ Number of children _____

Have you received acupuncture therapy before: ☐ Yes ☐ No If yes, then when _____

Who should we thank for referring you to our office (or how did you find us): _____

MEDICAL HISTORY

Please indicate any significant illnesses you or a blood relative (Grandparent, parent or sibling) have had:

Illness	You	Relative	Date	Illness	You	Relative	Date
Cancer	☐	☐	_____	Diabetes	☐	☐	_____
Hepatitis	☐	☐	_____	Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____	Seizures	☐	☐	_____
Rheumatic Fever	☐	☐	_____	Emotional Disorders	☐	☐	_____
Infectious Diseases	☐	☐	_____	Tuberculosis	☐	☐	_____

Sexually Transmitted Diseases _____

Medicine	Dosage	Reason	How long	Prescribed by	Date of last checkup

Continue on back of page if needed

Check the boxes if any of the following statements are true:

☐ I have known allergies ☐ I am taking Coumadin/warfarin ☐ I am pregnant

☐ I have a pacemaker ☐ I am taking lithium (Eskalith, Lithobid, Lithonate, Lithotabs)

Please indicate the use and frequency of the following:

	Yes	No	How Much		Yes	No	How Much		Yes	No	How Much
Coffee/black tea	☐	☐	_____	Tobacco	☐	☐	_____	Water Intake	☐	☐	_____
Non-medical drugs	☐	☐	_____	Alcohol	☐	☐	_____	Soda	☐	☐	_____

What are the main health problems for which you are seeking treatment?

What other forms of treatment have you sought?

List any allergies, food sensitivities, or food craving that you have.

List any accidents, surgeries, or hospitalizations (include date).

Lab results (please provide us with a copy).