WATKINS
ACUPUNCTURE
CLINIC

(240) 686- 5196
Acupuncture.Liza@gmail.com
www.WatkinsAcupunctureClinic.com

Office Policies and Consent to Services

Voluntary Participation:
I hereby voluntarily consent to treatment provided by Watkins Acupuncture Clinic. I acknowledge that the purposes, goals, techniques, procedures, limitations, potential risks and benefits of the service to be performed have been explained to me. I understand that I am free to discontinue services at any time.

Initial _____

Services To Be Provided:
Treatment may include Acupuncture and Zero Balancing. I understand that I may be treated with the insertion of needles and/or with the application of heat to the skin.

Initial _____

Risk/Possible Side Effects:
I understand that acupuncture may result in certain side effects, including local bruising, slight bleeding, fainting, temporary pain and discomfort and temporary aggravation of symptoms existing prior to treatment.

Initial _____

Infectious Disease Prevention:
I understand that infectious diseases are carried through the air, through physical contact and through body fluids. I understand that my practitioner follows universally prescribed precautions and procedures (such as clean needle technique and hand washing) to prevent the spread of disease.

Initial _____

Client Responsibilities:
I understand that it is my responsibility to inform my practitioner of all aspects of my health on the intake questionnaire, including any changes in my health status since my last service date. If there is a worsening of an ailment or condition, or if a new ailment or condition arises, I should consult a licensed physician. I also understand that if I am currently under a physician's care, I should continue as long as my physician and I deem it necessary. I further understand that my practitioner does not recommend altering medications or other therapies without first consulting my personal physician or health care provider and that the services at Watkins Acupuncture Clinic are not intended for the diagnosis or treatment of disease.

Initial _____

Privacy: I have received the Notice of Privacy Practices.

Initial _____

Fees and Charges:
I have been informed of the fees for service, and I understand that payment is due at the time when services are provided. We accept cash, credit cards, and personal checks. Please not there is a $25.00 charge for checks returned due to insufficient funds.

Initial _____

Insurance Coverage:
I understand that many insurance policies cover Acupuncture, but we do not claim that yours does. Policies can differ greatly in terms of deductible and percentage of coverage for Acupuncture. We can verify coverage and submit your claim form for reimbursement, provided you sign financial agreement below.

Initial _____

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Release of Information:
Your insurance company may require medical reports to document our treatment and progress. Your initials below authorize the release of medical information necessary to process your claim.

Initial _____

Cancelations:
As a courtesy to our office and other patients, we ask that you please notify the office at least 24 hours in advance if you need to cancel or reschedule your appointment. You will be charged a $50.00 fee for any missed appointment or cancellation giving less than 24 hours notice for any non- emergency situation.

Initial _____

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS

I, (print full name) _____, am receiving or about to receive health care services in this office. I understand that I am responsible to pay all non-insurance related fees when services are rendered. If I choose to use my insurance I understand I will be responsible for all “non covered” services and /or coinsurance/co-pays associated with my office visit. In addition I authorize insurance payment of medical benefits to Watkins Acupuncture Clinic, LLC.

By signing below, I agree to comply with the office policies stated above which I have read and understood. I also authorize the use of this signature on all insurance submissions.

X_____
Printed name of client

X_____
Signature of client or guardian

X_____
Date