Living Stream Wellness, Inc.

OFFICE POLICIES

Thank you for choosing us as your health care provider. The following policies and procedures are in place to ensure that our patient community enjoy professional, efficient, effective service. If you have any questions, please contact us to verify our office policies.

CANCELLATIONS, TARDINESS and NO SHOW:

- **Cancellations:** You will be billed for your reserved treatment time. Please give at least ***24 hours*** notice to cancel or reschedule your appointment. Cancellation without proper notice results in the following:

Package Rate Missed Appointment Policy:

Package Rate appointments will be forfeited and may not be rescheduled.

Per-Session Missed Appointment Policy:

Per-session Rate appointments will be billed at the $50 of full appointment fee.

- **Tardiness:** In the event that we are fully booked and you are 15 (or more) minutes late, you may receive a modified treatment or may not be able to be seen. Please be prompt to avoid **lateness fee of $50**.
- **No call, no shows** will not be rescheduled after your 2nd no call, no show. Your next few visits will only be made on a "walk-in" or same day basis. Thereafter, upon reevaluation, advance appointments would again be available.

FINANCIAL AGREEMENT:

Payment is due at the time of service in the form of credit card, all HAS/FSA (Flexible Spending Account) cards, check, or cash. $30 will be charged for a returned check and future payments must be made by alternate means.

I understand that I am financially responsible for all charges and services, including the balance after payment of possible insurance benefits or legal settlements, and charges for any missed appointments WITHOUT 24-HOURS NOTICE. I authorize payment of medical benefits to myself or the names provided for professional services rendered. I authorize release of any medical information necessary to process this claim.

____ / / ______

Patient/Parent/Guardian Signature Date Date

INSURANCE AGREEMENT:

Insurance carriers generally only cover acupuncture for pain related conditions and headaches. Health maintenance, internal conditions and fertility are non-covered conditions. You are financially responsible for treatment of all non-covered conditions. Some insurance policies will only cover the first 15 minutes of needle insertion or needling only. A comprehensive acupuncture treatment consists of a minimum of 30 minutes of needle retention time and it may incorporate other therapy modalities such as cupping, moxibustion, orthopedic massage, infrared heat lamp, hot packs, and gua-sha. In addition, herbal and dietary recommendations and therapeutic exercise may not be covered. Billed separately, these itemized therapies can add significant fees above your insurance coverage/deductible. If your insurance does not cover these modalities and or the treatment session you need, you will be given the option to refuse any additional therapies or you may accept comprehensive coverage/co-payment for any and all therapies deemed necessary for your treatment by your acupuncturist for an additional charge depending on your insurance coverage.

_____ I agree to pay an additional fee to cover any and all therapies that my therapist deems necessary for my health that are not covered by my insurance plan.

_____ I refuse any additional therapies beyond what is covered under my insurance benefits.

APPOINTMENT REMINDERS:

Consent for SMS Text & Email service I give my permission to the staff at Living Stream Wellness, Inc. to send me reminder notice of my scheduled appointments via SMS and e-mail service.

NOTICE OF PRIVACY PRACTICES:

A copy of the Notice of Privacy Notice is place on the writing clipboard. By signing below, you acknowledge that you have read/received a copy of Notice of Privacy Notice from Living Stream Wellness. You further acknowledge that a paper copy of the current Notice will be on file and will be available to you at you request during office hours, and that a current of the Notice is available to me at www.livingstreamwellnesstcm.com

By singing below, you are acknowledging your understanding of the office polices described above.

PATIENT PRINT NAME: ________________________________ PATIENT SIGNATURE: ____________________________ DATE: MM / DD / YYYY

(* Or Patient Representative) (* Or Patient Representative)

*To be completed by patient's representative if the patient is a minor or is physically incapacitated. Indicating relationship: ☐father ☐ mother ☐ legal guardian ☐ other:________________

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