Policies

Payment policy: All payments must be made at time of session unless other arrangements have been agreed to beforehand. I accept Cash, Check or Credit Card. I do not take insurance.

FSA and HSA accounts may allow reimbursement for acupuncture. The IRS defines which medical expenses are eligible under a tax-deferred account. However, employers may only allow some of these expenses with your plan. It's important to always check with your benefits administrator to determine which expenses are eligible.

Cancellation policy: Because of limited times available and high demand, it is necessary to enforce a strict cancellation policy. Last-minute cancellations are difficult to fill. By giving last-minute notice, or no notice at all, you prevent someone else from being able to schedule into that time slot.

If a client cancels or changes the appointment at least 24 hours prior to the appointment, there is no charge.

If a client cancels or changes the appointment less than 24 hours prior to the appointment, or does not show, the client will be charged for that session. \_\_\_\_\_\_\_\_\_\_ Initial

Late Policy: I provide you my fullest attention during your allotted time. Your respect of other client’s time is appreciated and sessions will end promptly as scheduled. Late arrivals are responsible for the full fee of the session.

Privacy policy: I am very concerned about protecting the privacy of your personal health information. The Health Insurance Portability and Accountability Act of 1996 (HIPPA) requires that your health practitioner supply you with a copy of their privacy policies and procedures.

Any information in your file will only be given to you, a doctor, or other organizations (health insurance company, lawyer, etc.) that you have authorized to see this information. Any requests for your file or information will first be referred to you for authorization. I do not mail, FAX or otherwise electronically transmit information until authorized by you to do so. If you have any questions or concerns regarding the use of dissemination of your personal health information, please contact me.

By signing below, you acknowledge you have read and understand the policies above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(printed name) (signature)

Date