COLLINGS ACUPUNCTURE & WELLNESS

HEALTH HISTORY FORM

Name _____ Date _____/_____/____
Preferred to be called _____ DOB ____ /_____/_____
☐Male ☐Female Height _____ Weight _____

Address: _____

City _____ State _____ Zip _____

Phone (home) _____ (work) _____

(cell) _____ E-mail _____

Preferred method of contact: ☐Email ☐Text (☐Cell ☐Home ☐Work)

Marital Status: ☐Married ☐Never Married ☐Widowed ☐Divorced or Separated

Education: ☐Grammar School ☐High School ☐College ☐Masters ☐Doctorate

Employer/ Occupation: _____ ☐Retired ☐Disabled ☐Unemployed

How many hours do you work per week? _____ Do you enjoy your work? ☐Y ☐N

Why/why not? _____

Do you have insurance? ☐Y ☐N Carrier:_____ Policy Number:_____

Emergency Contact/Relation: _____ Phone: _____

Family Physician: _____

Address: _____ Contact Number: _____

How did you hear about us? _____

Is there any chance you are pregnant? ☐Y ☐N If yes, how far along are you? _____

Is this your first acupuncture/bodywork/energy treatment? ☐Y ☐N
How frequently do you get acupuncture, bodywork? Energy work? _____

What do you hope to accomplish in treatment?_____

Do you have pain/tension anywhere in your body? ☐Y ☐N
If yes, where?_____

Chief complaint/ Reason for visit (symptoms, location, quality, mechanism of injury, diagnosis, duration, etc.)_____
_____
_____
_____
_____

Please answer the questions below if applicable. Please be as specific as possible:

- When did the chief complaint first begin? _____
- Have you been given a diagnosis for the chief complaint? If so, what diagnosis and by whom _____
- How long and how often does this bother you? _____
- Is the chief complaint related to trauma, accident, work, or others? _____
- Have you been seen any other professions for the same chief complaint? _____
- Severity of the problem on a scale of 0-10 (0 = best; 10 = worst): At its best: ___/10; At its worst: ___ /10; Average: ___ /10; Right now: ___ /10
- If there is pain involved, what is the pain level on a scale of 0-10 (0 = best; 10 = worst): At its best: ___ /10; At its worst: ___ /10; Average: ___ /10; Right now: ___ /10
- If there is pain involved, what is the quality of the pain? (Check all that apply) ☐ Dull ☐ Achy ☐ Burning ☐ Sharp ☐ Stabbing ☐ Cold ☐ Numb ☐ Tingling ☐ Throbbing ☐ Other: _____
- What makes the chief complaint feel better? (Check all that apply) ☐ Heat ☐ Cold ☐ Damp ☐ Wind ☐ Weather ☐ Rest ☐ Work ☐ Movement ☐ Sitting ☐ Lying ☐ Massage/Pressure ☐ Stress ☐ Other: _____
- What makes the chief complaint feel worse? (Check all that apply) ☐ Heat ☐ Cold ☐ Damp ☐ Wind ☐ Weather ☐ Rest ☐ Work ☐ Movement ☐ Sitting ☐ Lying ☐ Massage/Pressure ☐ Stress ☐ Other: _____
- To what extent does the chief complaint interfere with your daily activities (work, sleep, sex, etc.)? _____
- What kinds of treatment have you tried? ☐ Western Medicine ☐ Acupuncture ☐ Herbs ☐ Massage ☐ Physical Therapy/Occupational Therapy ☐ Chiropractor ☐ Reiki ☐ Homeopathy ☐ Other: _____

Any other complaints you'd like to address: _____
_____
_____

Current medications

Medication	Dosage	Reason for taking

Hospitalizations or surgeries (please include dates):_____
_____
_____

Significant trauma or injuries (*physical or emotional; auto accidents, falls, etc.*)

_____

_____

Allergies (medications, environmental, food, drugs, etc.): _____

Past Medical History (Please check the box):

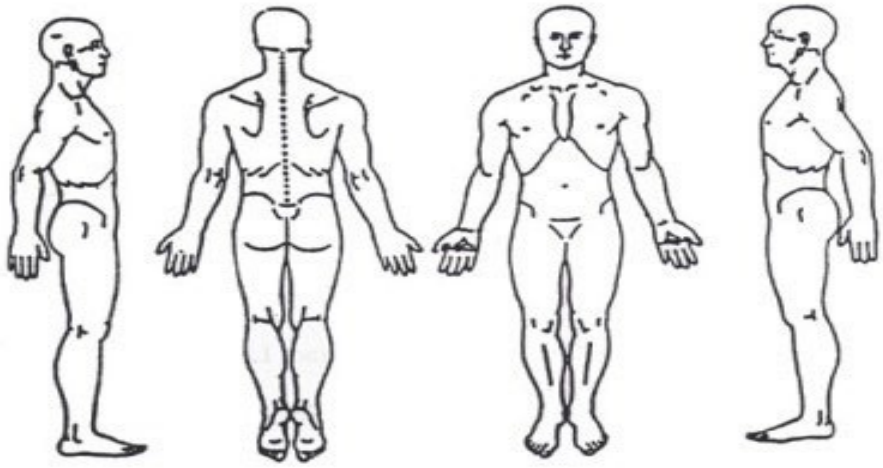
☐Diabetes ☐Osteoporosis ☐Blood Clots ☐Chest Pain / Angina ☐Asthma/COPD ☐Peripheral ☐Vascular Disease ☐High Blood Pressure ☐High Cholesterol ☐Stroke/CVA/TIA ☐Tuberculosis ☐Seizures ☐Depression ☐Anxiety ☐Heart Disease ☐Heart Attack ☐Heary Surgery ☐Congestive Heart Failure ☐Heart Palpitations ☐Pacemaker ☐Hepatitis ☐Thyroid Disease ☐Arthritis ☐Stomach Ulcer ☐Headaches ☐Liver Disease ☐Kidney Stones ☐Kidney Disease ☐HIV/AIDS ☐Cancer Type:_____ ☐Other (Please list):_____

Current Health Condition

ROS	Please check all **CURRENT** positive findings/complaints
Constitutional	☐Weight loss ☐Fevers ☐Chills ☐Poor appetite ☐Fatigue ☐Weight gain ☐Insomnia ☐Night sweats
Eyes	☐Blurry vision ☐Eye pain ☐Eye discharge ☐Eye redness ☐Decrease in vision ☐Dry eyes ☐Double vision
ENT	☐Sore throat ☐Hoarseness ☐Ear pain ☐Hearing loss ☐Ear discharge ☐Nose bleeds ☐Tinnitus ☐Sinus problems
Cardiovascular	☐Chest pain ☐Palpitations ☐Rapid heart rate ☐Heart murmur ☐Poor circulation ☐Swelling in the legs or feet
Respiratory	☐Shortness of breath ☐Chronic cough ☐Coughing up blood ☐History of Tuberculosis ☐Excess sputum production
Gastrointestinal	☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation ☐Blood in the stool ☐Frequent heartburn ☐Trouble swallowing
Genitourinary	☐Increased urinary frequency ☐Blood in the urine ☐Incontinence ☐Painful urination ☐Urinary retention ☐Frequent UTIs
Skin	☐Rash ☐Hives ☐Hair loss ☐Skin sores or ulcers ☐Itching ☐Skin thickening ☐Nail changes ☐Mole changes
Musculoskeletal	☐Joint pain ☐Muscle aches ☐Frequent leg cramps ☐Muscle weakness ☐Bone pain ☐Joint swelling ☐Back pain ☐Hip pain ☐Foot/Ankle pain ☐Carpal Tunnel Syndrome ☐Sciatica ☐Osteoporosis
Psychiatric	☐Anxiety ☐Depression ☐Alcohol or drug dependence ☐Suicidal thoughts ☐Panic attacks ☐Use of anti-depressants

Endocrine	☐Goiter ☐Heat intolerance☐Cold intolerance☐Increased thirst ☐Change in skin pigment ☐Excess sweating
Neurological	☐Seizures ☐Tremors ☐Migraines ☐Numbness ☐Dizziness/Vertigo Loss of balance ☐Slurred speech☐Stroke
Hem/Lymphatic	☐Low blood count ☐Easy bruising☐Swollen lymph nodes ☐Transfusions ☐Prolonged bleeding ☐Blood clots
Allergy/Immunology	☐Allergic reactions ☐Hay fever☐Frequent infections☐Hepatitis☐HIV positive ☐Positive tuberculin skin test (PPD)
Tobacco: ☐Non-Smoker (never smoked) ☐Ex-Smoker ☐Current Smoker How many packs per day?_____ Alcohol consumption: ☐Never ☐Occasional ☐Frequent How many drinks per day?____ week?_____	
Family History: (Please list any known medical problems) Father: _____ Mother: _____ Siblings: _____ Your Children: _____	

Please indicate with an X on the area(s) of the body where you experience pain:



Are there any areas of your life that you find stressful? Please describe: _____

_____

Do you have a regular exercise program? Days per week ____Length of workout _____

Type of Activity _____

Do you follow any type of special diet (e.g. vegetarian, vegan, medical related, or other)? If Yes, what type of diet? _____

Gynecological/Reproductive (Women Only) Are you pregnant? ☐ Yes ☐ No

Is it possible that you are pregnant? ☐ Yes ☐ No

Number of pregnancies: _____ Live Births: _____ Miscarriages: _____ Abortions: ____

Premature births: _____ Age at first menses: _____ Time period between menses: _____

Duration of menses: _____ Last PAP test: _____ Date of last menses: _____

Do you practice birth control? _____ What type?_____ How long?_____

☐ Irregular periods ☐ Painful periods ☐ Uterine Fibroids ☐ PMS

☐ Vaginal dryness/itching ☐ Polycystic Ovarian Syndrome ☐ Vaginal sores ☐ Clots

☐ Ovarian cysts ☐ Sexually transmitted disease ☐ Endometriosis ☐ Infertility

☐ Unusual character of blood (heavy, scanty)_____

☐ Fibrocystic breast tissue

Please complete the following menstrual chart:

	Day 1	Day2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (describe size: large, small, black, purple, red, other)							
Vomiting/nauseas (check if yes)							
PMS (what symptoms, duration of symptoms)							

Have you ever been treated for emotional problems? ☐ Yes ☐ No

Have you ever considered or attempted suicide? ☐ Yes ☐ No

Have you ever been treated for substance abuse? ☐ Yes ☐ No

The above information is accurate and true to the best of my knowledge. I understand that acupuncturists do not diagnose disease or prescribe medications. I further understand that acupuncture is not a substitute for medical attention or examination and treatment. I take responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health.

Signature : _____ Date : _____

PATIENT NAME:

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 state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

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, as to whether this agreement is unconscionable, and any procedural disputes, 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 to treatment or services provided by the healthcare 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 claim. This agreement is intended to bind the patient and the healthcare provider and/or other licensed healthcare providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the healthcare provider, including those working at the healthcare provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the healthcare provider, and/or the healthcare provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

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) and provide National Arbitration and Mediation ("NAM") with the party arbitrator's contact information within thirty days of the date Respondent files its initial responsive pleading. A third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties from a list of arbitrators supplied by National Arbitration and Mediation ("NAM") within thirty days thereafter. The list supplied by NAM shall be a list of between 5 and 10 arbitrators, depending upon availability. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's equal 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 counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of 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 state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that, where not in conflict with this agreement, the Healthcare Malpractice Dispute Resolution Rules and Procedures of NAM shall govern any arbitration conducted pursuant to this Arbitration Agreement. A copy of NAM rules are available on its website at https://www.namadr.com or by calling 1-800-358-2550 to request a copy of the rules.

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 statute of 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 healthcare 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 of 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 the 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 Name (print): _____ Signature: _____ Date: _____

Parent or Guardian (print): _____ Signature: _____ Date: _____

Office Name: _____ Signature: _____ Date: _____

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

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 the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, 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, electrical stimulation, Tui-Na (Chinese massage), 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 a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: 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. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic 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. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I agree with the current or future recommendations for care. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT NAME:

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

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

TREATMENT WARNINGS/PRECAUTIONS

Please completely fill out form, date each section and if nothing applies in the section for you, indicated with N/A. All sections must be dated to indicate you have read/acknowledged each section.

Name _____ Date ____/_____/_____

Street _____ City _____ State/Zip _____

Phone Number: _____

ALLERGIES (i.e. Food, medications, seasonal, topical, metals):
Date:_____

_____

_____

_____

_____

SIGNIFICANT MEDIAL HISTORY (i.e. pace maker, metal rods, trauma etc) that will impact treatment:
Date:_____

_____

_____

_____

_____ **SIGNIFICANT REACTION TO TREATMENT**:
Date: _____

_____

_____

_____

_____ **NON-CONSENT TREATMENTS:**
Date:_____

_____

_____

OTHER (any additional information you feel your acupuncturist should know):
Date:_____

_____

_____

_____

COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided) **Initial Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to- person contact, in which COVID-19 can be transmitted. _____

- I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____

- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. _____

- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below: _____

*Fever	*Dry Cough	*Sore Throat
*Shortness of Breath	*Runny Nose	*Loss of Taste or Smell

- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. _____

- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____

- I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient	Parent / Guardian	Witness

Signature: _____ Signature _____ _____

Signature _____ _____

Name _____ Name _____ _____

Name:

Date _____ Date Date:

COLLINGS ACUPUNCTURE & WELLNESS

Cancellation Policy

Booking an appointment means you have read and agreed to the following policy:

Thank you choosing Collings Acupuncture & Wellness for your healthcare needs – we look forward to working with you! An acupuncture appointment at our clinic is seen as a commitment between acupuncturist and patient. We always respect your time and ask you to do the same for ours.

Cancellation Policy:

We request 48 hours' notice for all rescheduled appointments and cancellations; due to the nature and size of our business **we REQUIRE 24 hours' notice** to not accrue a forfeiture fee. While we understand that situations come up and emergencies happen, we do not double-book the schedule and late cancellations and missed appointments greatly impact our practice.

Fees for missed appointments:

You may cancel or change your appointment up to 24 hours in advance of your treatment via our online booking feature. For changes or cancellations less than 24 hours in advance, **you will be charged a forfeiture fee of $60 for any acupuncture appointment and $40 for any other holistic treatment session; if you fail to show up for your initial appointment (two hours) you will be charged the full service fee.**

Late cancellations and missed appointments are NOT billable to your insurance regardless of your benefit coverage – you are required to place a credit card on file when booking online and are personally responsible for paying this fee. Also please note that treatment time is not extended for late arrivals. Thank you for understanding.

I, _____ understand that any change or cancellation of a scheduled appointment is preferred 48+ hours in advance and requires AT LEAST 24 hours' notice not to incur forfeiture fees. I understand that if changes or cancellation to my appointment are not made prior to this time frame or if I fail to show up for the scheduled appointment I will remain financially responsible for the payment in full prior to the next treatment.