Clinic Policies

Appointment Arrival
It is our goal that you enjoy your experience and leave feeling truly relaxed and rejuvenated. Please arrive 10 minutes prior to your scheduled appointment time. This will allow you time to check in and get comfortable. Arriving late will result in the loss of time toward your service and you will still be charged the full amount. If this is your first visit, please arrive 15 minutes early to allow extra time to fill out your personal profile.

Cancellation Policy We kindly ask that you give us 24 hours notice before a single service and 48 hours notice before multiple or packaged services. Failure to cancel within 24 hours will result in a full service charge. Please be prepared to provide your credit/debit card number at your initial appointment for this purpose.

Prepare for your Treatment
Preparation for your individual treatment is easy. If you are scheduled for an acupuncture appointment, please eat about an hour before your appointment time. Please wear loose fitted clothing for accessibility to the abdomen, arms and legs. For other services, please drink plenty of fluids, hydration is important.

Our Quiet Space
To maintain our environment, we ask that all cell phones be turned off during your time here. Please give your family members our office number for any emergencies and we will get you immediately. We wish to create a peaceful, healing space.

Payment
We currently accept cash, checks, and all credit cards.

We accept insurance. If you have insurance, please initial below and have your insurance card available.

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_____

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, including herbs, etc. 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 .

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.

*Signed*_____ *Date*_____