CLINIC POLICIES

We would like to take a moment to welcome you to our office and assure you that you will receive the very best care available for your condition. In order to familiarize you with the policies of this office we would like to explain how your medical bills and records will be handled.

Explanation of Insurance Coverage

Many insurance policies do cover acupuncture, chiropractic, naturopathy, and/or massage therapy care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for services at this clinic. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, copays, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner.

Assignment of Benefits

If your insurance carrier sends payments to you for services rendered in this office, you agree to send or bring those payments to this office upon receipt. If you pay for your visits in full, then the payments should be sent directly to you from the insurance company.

Release of Information

If your insurance company requires medical reports or records to document your treatment or progress, your signature below authorizes this office to release the medical information necessary to process your claim. “I hereby acknowledge that I have received a copy of this practice’s NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact the office. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way.”

Voluntary Termination of Care

If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately will be personally responsible for payment regardless of your insurance coverage.

Cancellation Policy

I am aware that a specific amount of time has been set aside for my treatment. Arriving late means that my treatment will be adjusted to fit into the time scheduled. I will give 24 hour notice of intent to cancel or reschedule my appointment, except in case of emergencies. Missed appointments will be charged a cancellation fee.

Email Disclosure

While we strive to maintain security, the email system used by New Life is not encrypted and so does not adhere to HIPAA standards. You may choose to opt out of receiving email with personal health information. Opt out _____

We hope this answers any questions you might have concerning the policies of this office. Once again we welcome you to our office, and will be glad to answer any further questions that you might have.

I have read and agree to the above. I have also read and understood the privacy policies of Lily M. Isaacson, L.Ac, EAMP.

PATIENT SIGNATURE _____ Date _____

PRINTED NAME _____

INSURANCE BENEFITS

Insurance is a contract between each patient and their insurance company. New Life Acupuncture Clinic is not a party in this contract. We will file claims on your behalf based on the information that you provide us. You are responsible for knowing and understanding the requirements and limitations of your coverage. You as the patient are ultimately responsible for payment of all services provided by our clinic, which may include portions not covered by your health insurance plan.

By initialing this statement, I understand the benefits quoted below are not a guarantee of payment, and are summarized as a patient service. I have been encouraged to verify my quoted benefits directly with my insurance company. *Initials*_____

PRIMARY INSURANCE PLAN DETAILS

Insurance Name:_____ **ID #:**_____ **Group #:**_____

Subscriber Name:_____ **Subscriber DOB:**_____

Patient Name:_____ **Patient DOB:**_____

The following is a summary of benefits provided to us by your insurance company:

Effective date: _____ □ Calendar Year □ Plan Year □ Other: _____

Deductible: _____ Out-of-pocket: _____ Limit: _____

Remaining: _____ Remaining: _____ Used: _____

Copayment: _____ % Covered: _____ Required for treatment: Rx / Referral / Pre-Auth

Combined With:
□Massage Therapy
□Chiropractic
□Naturopathic

SECONDARY INSURANCE PLAN DETAILS

Insurance Name:_____ **ID #:**_____ **Group #:**_____

Subscriber Name:_____ **Subscriber DOB:**_____

Patient Name:_____ **Patient DOB:**_____

The following is a summary of benefits provided to us by your insurance company:

Effective date: _____ □ Calendar Year □ Plan Year □ Other: _____

Deductible: _____ Out-of-pocket: _____ Limit: _____

Remaining: _____ Remaining: _____ Used: _____

Copayment: _____ % Covered: _____ Required for treatment: Rx / Referral / Pre-Auth

Combined With:
□Massage Therapy
□Chiropractic
□Naturopathic

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

By signing below, I agree to following the terms of service:

- ✓ I accept financial responsibility for my treatment. I authorize payment of medical benefits to be made directly to New Life Acupuncture Clinic.
- ✓ Payments of any required copayment are due at the time of service. Checks returned for non-sufficient funds will be subject to a $25 fee.
- ✓ If you have questions regarding your statement, please contact our office at (360) 218-4554.

Signed:_____ **Date:**_____

(Parent/Guardian signature if child is under 18 years old)

CONSENT FORM FOR ACUPUNCTURE AND HERBAL TREATMENT

Lily Isaacson graduated from Bastyr University (Kenmore, WA) with a Master's of Science degree in Acupuncture and East Asian Medicine in 2016. Didactic and clinical training were completed between September 2013-August 2016. State License is dated 12/30/2016. License No. AC 60718777.

Scope: East Asian medicine in the state of Washington includes, but is not limited to, the following: Acupuncture, including the use of acupuncture needles or lancets to directly and indirectly stimulate acupuncture points and meridians; Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians; Moxibustion (direct or indirect application of heat to acupuncture points or needles); Acupressure; Cupping (Cups made of glass or other materials placed on the skin with a vacuum created by heat or other device); Dermal friction technique ("Gua sha"); Infrared; Sonopuncture; Laserpuncture; Point injection therapy (aquapuncture); Dietary advice and health education based on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements; Breathing, relaxation, and East Asian exercise techniques; Qi gong; East Asian massage and Tui na (which is a method of East Asian bodywork); and Superficial heat and cold therapies.

Potential Risks of the treatments listed above may include, but are not limited to, the following: Pain following treatment; Minor bruising; Infection; Needle sickness; Potential burns and scarring, and numbness or tingling near the needling sites that may last a few days. Occasionally, needles can break. Bruising is a common side effect of cupping. Burning and/or scarring are a potential risk of moxibustion and cupping. Unusual risks of acupuncture include spontaneous miscarriage, 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.

Potential Benefits: In time, relief of symptom(s) including pain, stress, reduction of medications (with supervision from your MD), as well as improved sleep, energy and immune function.

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 who I am legally responsible) by the acupuncturist named above 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 above, 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 are listed above. I understand that the herbs prescribed to me may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be unpleasant in smell or taste. I will immediately notify a member of clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, which are listed above. 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. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. **I will notify a clinical staff member who is caring for me if I am or become pregnant. I understand that I must inform the clinic if I have a severe bleeding disorder or pacemaker prior to any treatment.**

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and 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 results are not guaranteed. I understand I am free to discontinue participation of these procedures at any time. 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 am aware that the practitioner allows a specific amount of time for each treatment and if I arrive late my treatment will be adjusted to fit her time schedule.

I understand that I must give 24 hours notice to cancel or reschedule my appointment. Late cancellation or a missed appointment may be billed at the current treatment rate.

By voluntarily signing below, I show 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 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 SIGNATURE _____ **Date** _____

PRINTED 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 health care 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 health care provider and/or other licensed health care 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 provider, including those working at the health care 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 health care provider , and/or the health care 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) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata 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 damage 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 the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

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 health care 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 SIGNATURE _____ **Date** _____

PRINTED NAME _____