new life acupuncture clinic

# CLINIC POLICIES

Welcome to New Life Acupuncture Clinic! We assure that you will receive the very best care available for your condition. This office welcomes and respects patients of all gender identities and sexual orientations. The following information explains how your medical bills and records will be handled.

**Explanation of Insurance Coverage**

Many insurance policies do cover acupuncture care but this office makes no representation that yours does. Because insurance policies vary greatly in terms of coverage, we require that you, the patient, verify your insurance benefits and be personally responsible for the payment of your deductibles, copays, and coinsurances, as well as any uncovered charges such as injections and herbal supplements to 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**

Appointments canceled or rescheduled with less than 24 hours notice are subject to a fee of $50. If you arrive more than 15 minutes after your visit was scheduled to be begin, your appointment will be canceled and subjected to the late cancellation fee. You must reach out by text or call to (360) 218-4554 or by email to billing@newlifeclinic.care or hello@newlifeclinic.care for your appointment to be considered canceled or rescheduled. Canceled appointments may be rescheduled through Lily’s online calendar at www.newlifeclinic.care.

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/GUARDIAN SIGNATURE** _____

**PRINTED NAME** _____ **DOB** _____ **DATE** _____

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# 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 you provide us. You are personally responsible for understanding your coverage, and are ultimately responsible for payment of all services provided by our clinic, which may include portions not covered by your health insurance plan.

## PRIMARY INSURANCE PLAN DETAILS

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

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

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

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

Please notify this office if you have a secondary insurance you would like to have billed.

## UNDERSTANDING INSURANCE COVERAGE

**Deductible** - The amount you pay for healthcare services each year before insurance pays a portion of your owed amount. **Copay** - A fixed amount you pay for a covered benefit at each visit. Some plans require your deductible is met before the copay benefit applies. Other plans will note that the deductible does not apply to acupuncture, meaning you pay a copay even if your deductible is not met. **Coinsurance** - A percentage of the cost of covered services that you pay for each visit. If your coinsurance is 10%, you pay 10% of the covered cost for service and your insurance pays the other 90%. Most insurance plans require your deductible is met before your coinsurance benefit applies.

Visits past your benefit limit will be billed at our cash price of $110 per follow up visit. The cash price for new patient visits is $170. Injections are not covered by insurance and are $35 for a single homeopathic herbal injection and $42 for an injection with two homeopathic herbs. B-12 (energy support) and B-6 (anti-nausea) shots are available for $20 per injection. Herbal supplements may be recommended and vary in cost.

Cash-pay packages and a senior discount on cash-pay services are available.

## 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.

✓ I will pay any required copayment at the time of service, and by choosing to save my payment card on file, I authorize this office to collect my copayment at the time of service. I understand that coinsurance amounts under $50 will be charged to my card on file when an Explanation of Benefits from my insurance is received by the clinic. Checks returned for non-sufficient funds will be subject to a $25 fee.

✓ If you have questions regarding your statement, please call or text our office at (360) 218-4554 or email Jamie at billing@newlifeclinic.care.

**PATIENT/GUARDIAN SIGNATURE** _____

**PRINTED NAME** _____ **DOB** _____ **DATE** _____

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# 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 was completed between September 2013-August 2016. License No. AC 60718777. State License is dated 12/30/2016.

**Scope of Treatment:** In the state of Washington, East Asian medicine 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; East Asian massage and Tui Na; Superficial heat and cold therapies; Moxibustion (direct or indirect application of heat to acupuncture points or needles); Acupressure; Cupping (cups made of glass or silicone placed on the skin using vacuum suction 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, dietary and nutritional supplements (from plant, animal and mineral sources); Breathing, relaxation, and East Asian exercise techniques (Qi gong).

**Potential Risks** of the treatments listed above may include, but are not limited to, the following: Pain during or 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. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Occasionally, needles can break. The clinic follows best practices and uses sterile, disposable needles and maintains a clean and safe environment to mitigate these risks.

**Potential Benefits:** In time, you may experience relief of symptom(s) including pain, tension, stress, reduction of medications (with supervision from your MD), as well as improved mobility, sleep, energy and immune function. It may take multiple visits to experience a sustained reduction of symptoms and improvement of overall health.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of treatment on me (or on the patient named below, for whom 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 for or associated with the acupuncturist named above, whether listed on 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 consumed according to the instructions provided orally and in writing. The herbs may be unpleasant in smell or taste. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will immediately notify a member of clinical staff if I experience 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 other side effects and risks may occur. I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment. During the course of treatment, I wish to rely on the clinical staff's expertise to take action in my best interest and base recommendations on the facts then known. I understand the herbs and nutritional supplements 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. I understand that I must inform the clinic if I have a severe bleeding disorder or pacemaker prior to any treatment.**

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 that all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I agree 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 at this office.

**PATIENT/GUARDIAN SIGNATURE** _____

**PRINTED NAME** _____ **DOB** _____ **DATE** _____

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# ARBITRATION AGREEMENT

**Article 1: Agreement to Arbitrate:** Arbitration is a private dispute resolution procedure. It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary, 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 unreasonable, and any procedural disputes, will also be determined by submission to 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 and 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/GUARDIAN SIGNATURE** _____

**PRINTED NAME** _____ **DOB** _____ **DATE** _____

18122 SR 9 SE, Ste D Snohomish, WA 98296 I (360) 218-4554 I hello@newlifeclinic.care