



The Healing Arts Center of San Diego

Personal Health History

Name: _____ Date: _____
Home Address: _____ Email: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Phone: _____
Occupation: _____ SS#: _____
Whom should we thank for referring you to the office? _____

Sex: M ☐ F ☐ Height _____ Weight _____ Birthdate _____ Age _____
Marital Status Married ☐ Single ☐ Divorced ☐ Widowed ☐ Life Partner ☐
Have you received acupuncture before? Y ☐ N ☐ With whom: _____

PLEASE INDICATE ANY SIGNIFICANT MEDICAL HISTORY IN YOU OR A BLOOD RELATIVE:

	You	Relative	Date		You	Relative	Date
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emotional/Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infectious Diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STDs:	Gonorrhea <input type="checkbox"/>	Syphilis <input type="checkbox"/>	HIV/Aids <input type="checkbox"/>	HPV <input type="checkbox"/>	Herpes <input type="checkbox"/>		

PLEASE LIST ANY MEDICATIONS/SUPPLEMENTS THAT YOU ARE TAKING (Continue on back if necessary):

Medicine	Dosage	Reason	How Long	Prescribed by	Date of last check-up

Please indicate the use and frequency of the following:

	Yes	No	How Often		Yes	No	How Often
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recreation Drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____	Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Soda Pop	<input type="checkbox"/>	<input type="checkbox"/>	_____	Water Intake	<input type="checkbox"/>	<input type="checkbox"/>	_____

I certify that my Personal Health History is complete and true to the best of my knowledge. I understand that my medical records are completely confidential and are locked at all times, and compliant with personal health information guidelines under HIPAA. No personal information will be released to any other medical provider without my written permission.

Signature

Date

For Women

Age of 1st period (menarche) _____

Age of last period (menopause) _____

Number of days between periods _____

Number of days of flow _____

Color of flow _____

Clots? ☐ Yes ☐ No Color _____

Average number of pads you use per day: 1st day _____ 2nd day _____ 3rd day _____ 4th day _____ + days _____

Have you been diagnosed with: ☐ Fibroids ☐ Fibrocystic Breasts ☐ Endometriosis ☐ Ovarian Cysts ☐ PID Other _____

Location of Pain: ☐ Lower abdomen ☐ Lower back ☐ Thighs ☐ Other _____

Nature of Pain (Please indicate before, during or after menses)

Cramping _____	Stabbing _____	Other Symptoms related to menses <input type="checkbox"/> Discharge <input type="checkbox"/> Vaginal dryness <input type="checkbox"/> Headache <input type="checkbox"/> Nausea <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Swollen breasts <input type="checkbox"/> Mood swings <input type="checkbox"/> Ravenous appetite <input type="checkbox"/> Poor appetite <input type="checkbox"/> Hot flashes <input type="checkbox"/> Night sweats <input type="checkbox"/> Increased libido <input type="checkbox"/> Decreased libido <input type="checkbox"/> Insomnia
Burning _____	Aching _____	
Dull _____	Bloating _____	
Consistent _____	Intermittent _____	
Bearing down sensation _____		

For Men

Date of last prostate check up _____ PSA results _____ Manual prostate exam results _____

Lab results _____

Frequency of Urination: daytime _____ nighttime _____ Color of urine: ☐ clear ☐ murky odor: _____

Symptoms related to prostate

<input type="checkbox"/> prostate problems	<input type="checkbox"/> Delayed stream	<input type="checkbox"/> Dribbling	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Retention of Urine
<input type="checkbox"/> Rectal dysfunction	<input type="checkbox"/> Increased libido	<input type="checkbox"/> Decreased libido	<input type="checkbox"/> Premature ejaculation	<input type="checkbox"/> Impotence
<input type="checkbox"/> Back pain	<input type="checkbox"/> Groin pain	<input type="checkbox"/> Testicular pain	other _____	

Symptom Survey (For Everyone)

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:
 no mark () = never experience check mark (✓) = sometimes experience plus sign (+) = frequently experience

_____ lack of appetite _____ excessive appetite _____ loose stool or diarrhea _____ digestive problems, indigestion _____ vomiting _____ belching, burping _____ heartburn/reflux _____ feeling the retention of food in the stomach _____ tendency to become obsessive in work, relationships... _____ insomnia, difficulty sleeping _____ heart palpitations _____ cold hands and feet _____ nightmares _____ mentally restless _____ laughing for no apparent reason _____ angina pains	_____ abdominal pain _____ chest pain _____ sciatic pain _____ headaches _____ pain or coldness in the genital area _____ cough _____ shortness of breath _____ decreased sense of smell _____ nasal problems _____ skin problems _____ feeling of claustrophobia _____ bronchitis _____ colitis or diverticulitis _____ constipation _____ hemorrhoids _____ recent use of antibiotics	_____ eye problems _____ jaundice (yellowish eyes or skin) _____ difficulty digesting oily foods _____ gall stones _____ light colored stool _____ soft or brittle nails _____ easily angered or agitated _____ difficulty in making plans or decisions _____ spasms or twitching of muscles _____ low back pain _____ knee problems _____ hearing impairment _____ ear ringing _____ kidney stones _____ decreased sex drive _____ hair loss _____ urinary problems	_____ fatigue _____ edema _____ blood in stool _____ black tarry stool _____ easily bruised _____ difficult to stop bleeding _____ asthma _____ tendency to catch colds easily _____ intolerance to weather changes _____ allergies _____ hay fever _____ dizziness _____ tendency to faint easily _____ high cholesterol levels _____ sudden weight loss
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What are the main health problems for which your are seeking treatment?

What other forms of treatment have you sought?

List any other health problems you now have.

List any allergies, food sensitivities or food craving that you have.

List any accidents, surgeries, or hospitalizations (include date).

Lab Results: (please include copies)

Clinical Notes

(Intern's Use)

HPI:

- | | | | |
|------------------------------------------|------------------------------------------|------------------------------------|------------------------------------------|
| <input type="checkbox"/> Onset | <input type="checkbox"/> Location | <input type="checkbox"/> Duration | <input type="checkbox"/> Characteristics |
| <input type="checkbox"/> Aggravate/allev | <input type="checkbox"/> Related factors | <input type="checkbox"/> Treatment | <input type="checkbox"/> Significance |

How do you FEEL about the following areas of your life?

Please check the appropriate boxes and indicate any problems you may be experiencing.

Great Good Fair Poor Bad

significant

other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spirituality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your Comments

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including 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.

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 health care 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 X	(Date)
(Or Patient Representative) (Indicate relationship if signing for patient)	

OFFICE SIGNATURE X	(Date)
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ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

ACUPUNCTURE INFORMED CONSENT TO TREAT

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 have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including 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 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.

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.

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 results are not guaranteed.

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.

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.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE

X

(Or Patient Representative)

(Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE



The Healing Arts Center of San Diego

Notice of Privacy Practices

We will keep your health information confidential, using it only for the following purposes:

1. **Treatment:** We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.
2. **Disclosure:** We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.
3. **Payment:** We may use and disclose your health information to seek payment services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.
4. **Emergencies:** We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up receipts or invoices, copies of any forms of health information and/or supplies unless you have advised otherwise.
5. **Healthcare Operations:** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.
6. **Required by Law:** We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.
7. **Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.
8. **Public Health Responsibilities:** We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.
9. **Marketing Health-Related Services:** We will not use your health information for marketing purposes unless we have your written authorization to do so.
10. **National Security:** The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence, or other national security activities, we may disclose it to authorized federal officials.
11. **Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health care information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request from. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. We reserve the right to charge an amount for each page of documentation, if copies are requested, and an hourly fee for the time required to locate and copy your health information. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting April 14, 2003. Information prior to that date would not have to be released. (Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This must be submitted in writing.

Questions and Complaints

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Practice Name:	The Healing Arts Center of San Diego
Name of Privacy Officer:	Jennifer Moffitt, L.Ac., Director
Practice Address:	2515 Camino del Rio South, #110 San Diego, Ca 92108 PH: 619-688-0061 Fx: 619-688-0026



The Healing Arts Center of San Diego

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

Consent to Disclose Healthcare Information

By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of treatment, various activities associated with payment and health care operations. Our Notice of Privacy Practices provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our Notice of Privacy Practices, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to revoke your Consent by giving written notice to our Policy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this Consent Form after you have signed it.

(To Be Completed by Patient or Patient's Representative)

I, _____, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

Patient's Signature or Signature of Patient's Representative

Date

Printed Name of Patient's Representative

Relationship to Patient

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation, it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other (Please provide specific details):

Employee signature

Date



The Healing Arts Center of San Diego

Patient Care Financial Agreement for Patients 24-Hour Cancellation Policy

We are a unique acupuncture office, and we strive to provide quality affordable care with a great deal of personal time and attention given to each patient. In order to do this, we do not overbook, try to keep wait times to a minimum, and strive to honor the time of both the patient and practitioner. Time management and respect of time are critical factors for effective treatment.

- There is a **\$50 fee** for cancellations without 24-hour-notice. _____
Initial

The cancellation policy is strictly enforced for all patients.

We understand that issues arise with work and family care, and we are generous with our policy which is why we encourage you to call us if something comes up.

We reserve the right to refer you to another provider after the second missed appointment without a phone call.

- Patients who arrive more than 15 minutes after their appointment time without a call may have a reduced treatment time. _____
Initial

After the second missed appointment, HAC patients will need to pay in advance for their sessions.

I have read and understand the Patient Care Financial Agreement.

Signature

Date