Ni-Fei Hsieh, L.Ac. of New Jersey Acupuncture & Wellness Center
(973) 998-8433, f: (973) 528-9803, nhsieh1@gmail.com, http://www.cmHarmony.net

Financial Agreement Health Insurance

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

24-hour Cancellation Policy
We aim to provide our clients the highest quality service and pride ourselves on our exceptional team. If you should cancel your reservation less than 24 hours of your scheduled appointment, we not only lose your business, but also other clients who may have taken your scheduled reservation time. For this reason we are obligated to compensate our team for their time as well as make up for lost revenue. The full service fee will be charged to you for missed reservations that are rescheduled or canceled less than 24 hours notice.

Explanation of Insurance Coverage:
Many insurance policies do cover acupuncture care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for acupuncture care. 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, as well as any unpaid balances in this office. We will do our best to bill your insurance in a timely manner.

Payment Arrangement
We require that you pay your co-pay or any deductible on each visit. Your full portion of the balance is expected to be paid when payment is received from your insurance carrier. Any unpaid balances will be considered past due 30 days following insurance reimbursement. Past due balances may have an interest charge of 1.5% applied per month.

For **Medicare** patient who has a secondary insurance that pays for acupuncture, we will submit claims to Medicare first and then Medicare will mail Explanation of Benefit that indicates denial of Acupuncture service. It's your responsibility to get those forms to us so we can submit to your secondary insurance for payment. If these Medicare letters are not mailed/faxed to us within 40 days from date of service, you will end up responsible for payment because your secondary insurance will deny payment for your service and you will be responsible for the service instead.

Assignment of Benefits
By signing this form you are authorizing that payment of medical benefits will be made directly to this office. If your insurance carrier sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt. However if you pay for your visits in full the assignment will not be reported by this provider and any payment will be sent directly to you.

Release of Information
By signing this form you are also authorizing this office upon request from your insurance carrier the release of any medical or other information necessary to process the claim. You also acknowledge and request payment of government benefits either to myself or to the party who accepts assignment, namely this office.

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.

Testimony
(initial)_____ I, _____, hereby authorize New Jersey Acupuncture & Wellness Center the permission to use video, statement and testimony of my treatment performance to display for other patients in the public to help them understand how they can be helped by acupuncture & Chinese Medicine.

I have read and agree to the above

_____ _____
Patient Signature **Date**

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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

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PATIENT INFORMATION

Last Name_____ First Name_____ Date of Birth: ____/_____/_____

Social Security #:_____ Gender: □ M □ F Referred by:____ _____

Street:_____City: _____

State: _____ Zip: _____ Occupation: _____

(phone / email may be used when we have the appointment reminder system in the future)

Work Phone: _____ Cell Phone: _____

Home Phone: _____ Email: _____

EMERGENCY CONTACT

Name: (LAST)_____(FIRST)_____

Relationship to Patient: _____ Phone: _____

INSURANCE INFORMATION

Company: _____ Insured Name: _____ Insured's Birth date: ____/____/____

Relationship to Patient: _____ I.D Number: _____ Group #:_____

□ WORKERS' COMPENSATION / □ AUTOMOBILE ACCIDENT (circle the applicable one)

Claim #: _____ Date of Accident:____/_____/_____ Employer:_____

Currently Working: Yes / No Able to Work: Yes / No Description of the Accident:_____

_____

_____

Any Pre-existing injury to the same body part? If yes, state body part:_____

CURRENT HEALTH HISTORY

1) What are the main conditions you would like to be helped with?

_____

2) How long has it been since you first noticed any symptoms?

_____

3) Was your problem diagnosed by a physician or chiropractor? If so, what is it?

_____

4) What type of treatments or therapies have you tried?

_____ _____

Patient Signature **Date**