HARBOUR COMMUNITY ACUPUNCTURE LLC

Financial Agreement

Harbour Community Acupuncture has no relationship with insurance companies. We will happily provide you with paperwork you can submit to your insurance company if you would like to try to receive reimbursement. We offer no guarantee that your insurance will or will not pay for your acupuncture treatment.

Payment is due at time of service. We accept cash, major credit cards, and checks. Please be advised we charge a $35.00 fee for a bounced check.

Cancellation Policy

Please give 24 hours notice if you need to cancel or reschedule. Missing your scheduled appointment time compromises the effectiveness of your treatment plan, and keeps others from being able to make an appointment in that time slot. ***You may be charged a "no show" fee of $20 if you fail to cancel your appointment in a timely manner***. Thank you for your understanding.

Privacy Policy

Your privacy is important to us. Your healthcare information may be shared between the practitioners within Harbour Community Acupuncture. We will never share your private healthcare information with an outside source unless we have your written consent or otherwise required by law. We do not transmit health related information electronically.

Acupuncture Informed Consent

Acupuncture involves the insertion of pre-sterilized, disposable needles into specified points on the body in order to affect a change. In most cases the changes are pleasant and lead to healing. In some cases there may be side effects such as: bruising, discomfort, redness, slight bleeding, fainting, temporary pain/ discomfort/ dizziness or weakness, and temporary aggravation of symptoms existing prior to treatment. While this outlines the most commonly occurring adverse effects of treatment, other effects and risks may occur. Please be in communication with your practitioner if you have any concerns. We make no attempt to replace your primary care doctor. We encourage you to see your doctor when necessary and to have routine checkups. We are happy to refer you to the appropriate medical professional should the need arise.

By signing below you demonstrate your consent to treatment and acknowledgement of our above practice policies. You further acknowledge that no guarantee has been given regarding the results you may see during the course of your treatment. You are free to withdraw your consent and discontinue participation in acupuncture treatment at any time.

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Printed Name of Patient

_____ _____

Signature Date