Ageless Acupuncture

HIPPA Policy: I consent to the use or disclosure of my protected health information by Cheryl McCarthy, L.Ac., MacOM for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Ageless Acupuncture is not required to agree to the restrictions that I may request, however, if Ageless Acupuncture agrees to a restriction that I request, the restriction is binding on Ageless Acupuncture.

I have the right to revoke this consent, in writing, at any time, except to the extent that Ageless Acupuncture has taken action in reliance on this Consent.

Message Leaving Policy: Cheryl McCarthy, L.Ac., MacOM may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

Payment Policies: In an attempt to make my services available to as many patients as possible on an affordable basis, I require full payment at the time of service. I accept credit cards, cash and checks.

Insurance: Patients are responsible to make payment in full at the time of service. However, if your treatment is covered by your health insurance, I will assist you by providing the necessary forms so that you may get reimbursement from your insurance company. Please let me know if there are specific forms that your insurance company requires.

Please remember that treatments are rendered to the patient, not the insurance company. Thus, the insurance company is responsible to the patient and the patient is responsible to us for the account. The patient is responsible for checking on non-payments or disputing the amount of the payment. I do not render services on the basis that an insurance company will pay your fees.

Missed Appointment Policy: I understand and agree that I am personally responsible for payment for appointments missed without 24 hours notice in advance, and it is not the responsibility of any third party payer to make payments on my missed appointments. Missed appointments are billed at 50% of regular office visits, and I am aware of the existing fee presently in effect.

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Signature of Patient or Personal Representative Printed Name of Patient

_____ _____

Description of Personal Representative's Authority Date

_____ _____