ACUPUNCTURE
ACKNOWLEDGEMENT OF RECEIPT FOR NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Name (Please Print)

Patient or Authorized Representative (If applicable)

_____ _____

Signature Date

CANCELLATION OR MISSED APPOINTMENT POLICY

Research in the United States (as well as thousands of years of tradition in Asia) has shown that acupuncture is most effective when done frequently and regularly. Scheduling and keeping appointments is an important part of your treatment plan. Please help keep acupuncture rates affordable by providing at least 24 hours notice before rescheduling or cancelling your session. If you must cancel last minute and the appointment time is unable to be filled, I expect you to pay the full cost of your session. If it is a true emergency, I ask that you split the cost with me. If I cancel on you with less than 24 hours notice, I will give you a free treatment.

Thank you for your understanding regarding this policy.

I, _____, have read and understand the above mentioned policy.

_____ _____

Signature or Signature of Parent if a minor Date