Red Bird Acupuncture
Abi Morrison L.Ac.
17 Masonic Street,
Rockland, Maine 04841.

Informed Consent

I , _____ voluntarily consent to be treated with acupuncture by licensed acupuncturist Abi Morrison. I have read and understand the following.

- I understand that acupuncture will be performed by the insertion of sterile disposable needles in the skin or by application of heat (moxabustion), or by use of suction cups, cold laser, or by gentle scraping (gua sha) or some combination of the foregoing, at certain points of the body.
- I understand that although rare, certain side effects may result from my acupuncture treatment. These could include some minor discomfort, fainting,nausea, localized bruising, infection, nerve irritation/impairment, pneumothorax, or the temporary aggravation of pre-existing conditions.
- I accept that no guarantee is made concerning the outcome of my acupuncture treatments and that I am free to stop at any time.
- I do not expect the acupuncturist to be able to anticipate and explain all the risks and complications, and I wish to rely on the acupuncturist to exercise judgement during the course of the procedure, based on the facts then known.
- I have read, or had read to me, this consent form. I have also had an opportunity to ask questions about its content,and by signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition.
- I, the undersigned consent to the acupuncturist consulting with my physician or counselor (circle one or both) regarding my condition if she sees fit. I understand the contents of this form and consent to the procedure.

Patient Signature Date:

Witness Signature Date:

Parent / Guardian Signature Date:

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Health & Medical History

Today's Date: _____

Name:	D.O.B.:	Phone:	Email:
Address:	Cell #:	Work:	Occupation:
Physician:			
Current Health Concerns:			
Duration:			
Other Treatments or Therapies:			
Medications and Supplements:			
Other Health Concerns:			
Significant Injuries, Surgeries, or Illnesses, including dates:			
Family Health History - Illnesses, Age & causes of death of Parents and Grandparents:			
What sort of Exercise do you enjoy and how often?			
How do you relax?			

Circle those that apply to you. <u>Underline</u> to indicate family history.

AIDS, Alcoholism, Allergies, Anorexia, Asthma, Birth Trauma, Bladder Issues, Bulimia, Cancer (Type), Dental Work, Diabetes, Drug Addiction, Gall Bladder Issues, Heart Disease, Hepatitis A/B/C, Herpes, HIV+, Hyper-Active Thyroid, Hyper-Tension, Hypo-Active Thyroid, Kidney Issues, Lyme disease, Multiple sclerosis, Pacemaker, Parkinson's, Polio, Rheumatic, Scarlet Fever, Seizures, Shingles, Stroke, Tuberculosis, Ulcers.

Other (Please describe):

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Nutrition History

Today's Date: _____

Describe typical meals, including drinks.

Breakfast:	Lunch:	Supper:
Food preferences:		
Food intolerances:		

How often do you eat the following?

Times per Day/Week.

Meat, Fish:	Coffee, Tea:	Soda, Sweets:	Dairy:

How many times per day/week of the following?

Water:	Alcohol:	Nicotine:

Optimal Nutrition

☐ **Would you like a free nutrition consultation?** - Be sure to let me know if you would like to receive nutritional insights that could help to improve your condition and quality of life!

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Appointment Policy

Welcome to Red Bird Acupuncture. We are delighted to have you as a patient and look forward to providing you with the highest quality care. In order to optimize your relationship with us, please take a minute to read our appointment policy.

Many of our clients are pleased to find out that we are usually on time. This is because a treatment room has been reserved for you, whereas most medical offices overbook by appointment several patients at the same time. That kind of scheduling provides the practitioner with a steady flow of patients by but does not respect the patient's time.

Occasionally, there is a a problem with patients who are not used to staying on schedule themselves. With that in mind, if you are going to be more than 15 minutes late, please call to confirm availability.

A 24-hour notice for canceled or rescheduled appointments is necessary in order to avoid a cancellation fee of $75. This allows us time to schedule another patient that would also benefit from treatment. This appointment policy allows us to develop a mutual consideration and respect for our time and yours.

Any questions regarding my appointments have been addressed. I have read this statement and I fully understand it.

Print name in full	Print name of representative if represented by another
Signature	Signature of representative
Date	Date

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Time of Service Payments

In an effort to minimize costs and to create the best possible atmosphere for healing, we have made the following adjustments to our usual and customary rates. We are able to do this because paying at time of service frees this office from time-consuming paper work and tracking of filed insurance claims.

At your initial visit, you will be responsible for the new patient office visit fee that will be included on your bill. At each follow-up visit, you will be responsible for the established patient office visit fee that will be included on your bill. However, there are several procedures that may be used during your visit (initial and/or follow-up). Any of the following procedures used during your treatment will be reduced to $0.00, and you will be responsible for the office visit fee only.

97810 -	Acupuncture Initial 15 Minutes $75 per unit	97813 -	Acupuncture w/ Electrical Stimulation Initial 15 Minutes $100 per unit
97811 -	Acupuncture Additional 15 Minutes $75 per unit	97814 -	Acupuncture w/ Electrical Stimulation Additional 15 Minutes 100 per unit
97010 -	Heat Therapy $40	97140 -	Manual Therapy or Tui-Na Massage 15 min $75 per unit
97014 -	Electrical Stimulation (unattended) 15 minutes $45	97530 -	Kinetic Activities $45
97032 -	Electrical Stimulation (attended) $45	97110 -	Therapeutic Exercises $45
99070 -	Needles Laser therapy or moxa therapy 15 min $75		

- **$110.00** fee for the first office visit.
- **$75.00** fee for ongoing care.

Any questions regarding acupuncture payments have been addressed. I have read this statement and I fully understand it.

Print name in full

Print name of representative if represented by another

Signature

Signature of representative

Date

Date

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Office Financial Policy and Authorization to Bill Insurance

There are two billing options available for you. **Please select the one you prefer us to use for your visits.** If at any time if you choose to change your billing option, you are required to let us know immediately and sign a new Office Financial Policy and Authorization to Bill Insurance Form.

- ☐ **Private Pay** - Private Pay patients are patients that do not bill insurance. This discounted cash rate is only applied to the published rate if you pay at the time of service.
- ☐ **Insurance Billing** (Medical or Auto Insurance) - I understand that I must pay all co-payments and/or co-insurances not covered by my insurance company at the time of check in for today's visit, and every visit hereafter. Red Bird Acupuncture will submit my claim for me to my insurance company. Although Red Bird Acupuncture verifies my insurance; I understand that this verification is not a guarantee of payment. I understand that any and all charges incurred at this office including co-payment, co-insurance, percentage due and/or deductibles or any other fees or services not covered by my insurance company are my responsibility. I understand that if these patient portions due are not paid at the time of service I will be subject to a $10.00 billing fee per month – no exceptions until the outstanding amounts are paid. I further understand that any unpaid balance over 90 days, can and will be sent to collections for recovery unless prior arrangements have been made.

I authorize my insurance benefits to be paid directly to Red Bird Acupuncture. I also authorize the doctor to release any information and medical records required by my insurance company. I understand that I may revoke this consent by written request, at any time. No other records shall be released without my signed consent.

Signature of Responsible Party Date: