WHIDBEY
ACUPUNCTURE
+ HERBS

POLICIES

Please initial each box to signify understanding & agreement.

☐ I understand that full payment is expected at the time of service, unless prior arrangements have been made. Payment may be in the form of cash, check, or card (credit cards are subject to a 3% fee). The fee for returned checks is $40.

☐ I agree to provide at least 24 hours notice by telephone in the event that I need to reschedule or cancel an appointment. I understand that the time is set aside for me, and that if I fail to provide 24 hours notice that I am accountable for the cost of the session.

☐ Whidbey Acupuncture + Herbs is happy to provide itemized, medically coded superbills for insurance/HSA reimbusement purposes, as well as detailed, itemized receipts for tax purposes or other records. Please allow 2-4 weeks.

☐ Herbs and other consumable products are non-refundable (even if "unused' or "unopened"). In the event of a partial service package refund, all used sessions will be deducted from the total paid at the regular, pay-as-you-go, full rate. All refunds will be provided in the original form of payment within 2 weeks of request. All unused sessions expire after 1 year from the purchase date and will not be refunded after that point. Any refund requests must be made prior to the 1 year expiration date.

Privacy Policy

By voluntarily signing below, I show that I have read or have had read to me, the Notice of Privacy Practices, and have had an opportunity to ask any questions.

Printed Name of Patient _____ Patient Signature _____ Date _____

Printed Name & Signature of Legal Guardian (if applicable) _____

Disclosure & Consent

By voluntarily signing below, I show that I have read or have had read to me, the Disclosure & Consent to Chinese Medical Treatment and Care, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask any questions. By signing below, I consent to the treatment plan. I intend this consent to cover the entire course of my treatment, regardless of which condition is being primarily addressed.

Printed Name of Patient _____ Patient Signature _____ Date _____

Printed Name & Signature of Legal Guardian (if applicable) _____