1st CHOICE Acupuncture & Herbal Medicine

CONSENT TO CARE AND FINANCIAL RESPONSIBILITY

MEDICAL TREATMENT: I, the undersigned, hereby consent to and permit my attending acupuncturist and his/her designees, 1st Choice Acupuncture Inc., its employees, and all other persons caring for me to provide me treatment and care as may be deemed necessary and available to me. I understand that my care is under the control of my attending acupuncturists who may not be employees or agents of the clinic, but rather, independent entities, and that 1st Choice Acupuncture Inc. is not liable for their acts or omissions or any acts or omissions occurring from following their instructions. I am aware that practice of medicine is not an exact science, and acknowledge that no guarantees or promises have been made to me as to the result of the treatment or examination. **CONSENT TO CARE CONTINUES ON THE ADDENDUM.**

PRESENCE OF OBSERVERS: For the purposes of training and quality assurance, I consent to the presence of observers during tests, examinations, treatments, and other procedures.

RELEASE OF INFORMATION: I hereby authorize 1st Choice Acupuncture Inc. to disclose all or any part of my record, and any other information in the clinic's possession, to any person or entity which is or may be liable for all or part of the charges related to my care at 1st Choice Acupuncture Inc., including, but not limited to worker's compensation carriers, insurance companies, welfare funds, or my employer. I hereby release 1st Choice Acupuncture Inc. from all legal responsibility or liability which may arise from disclosure of my record as provided in this paragraph. I hereby authorize 1st Choice Acupuncture Inc. to furnish requested information of excerpts from my record to any insurer, its intermediary, or another healthcare facility to provide continuity of care. I understand that I may request to review my record (a 24 hour notification is required). I understand that I may request a copy of all or any part of my record, (there is a charge for this service). Except as noted above, 1st Choice Acupuncture Inc. will not disclose my record to others unless I direct it to do so, or unless the law authorizes or compels it to do so.

I CERTIFY THAT I HAVE READ THE FOREGOING AND THAT I UNDERSTAND ITS CONTENT. MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION.

PATIENT SIGNATURE:	X (Date)

(Or Patient Representative) (Indicate relationship if signing for patient)

FINANCIAL AGREEMENT: I understand that I am financially responsible for all charges, whether or not paid by my insurance. I am aware that some, and perhaps all, of the services provided may not be covered under insurance. I hereby instruct my insurance direct payment, as well as reimburse checks under my name to be mailed directly, to 1st Choice Acupuncture Inc. I am also aware that verification of insurance benefits is not a guarantee of payment. I authorize the use of this signature on all insurance submissions. **FINANCIAL AGREEMENT CONTINUED ON ADDENDUM.**

Initials*________

SCHEDULE POLICY: 1st Choice Acupuncture Inc. has a **24 Hour Schedule Policy**. This applies to all rescheduled, cancelled, missed, or no-show appointments. I understand that if I fail to give the clinic 24 hours advanced notice of a change of appointment, I will be charged a **$60** fee for that appointment, which will be donated to Washington Women in Need.

Initials*________

I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES, THE CONSENT TO CARE ADDENDUM AND FINANCIAL AGREEMENT ADDENDUM.

Initials*________

*Initials imply full signature

❑ **I WOULD LIKE A COPY OF THIS DOCUMENT**