LORAN SCRUGGS

Licensed Acupunturist

Classical Five Element Acupuncture

Name _____ Birth Date _____

Phone (home) _____ (cell) _____ (work) _____

Address _____ City_____ State _____ Zip _____

Employed By _____

Closest Friend or Relative_____ Phone _____

Physician _____ Phone _____

Address _____ City _____ State_____ Zip_____

Other Care Providers _____

Patient Referred By _____

If patient is a Minor
Responsible Parent or Legal Guardian _____

I hereby accept responsibility for treatment charges and for missed appointments or cancellations with less than 24 hours notice.
I understand that payment is due on the day of treatment unless other arrangements have been made prior to treatment.

Signature of Patient_____ Date _____

If not signed by patient, please indicate relationship to patient (e.g., mother) and patient's name.

Signature of Parent/Legal Guardian_____ Date _____

Consent for Care

I do hereby voluntarily consent to be treated by acupuncture administered by Loran Scruggs, Licensed Acupuncturist.

I understand that treatment may include manipulation of the skin, massage, application of heat (moxabustion), and/or insertion of fine sterile needles on or near the surface of the skin, and that all needles will be removed prior to completion of each visit.

I understand that I may experience temporary side effects from treatment such as local bruising, bleeding, lightheadedness, fainting, pain or discomfort and the possible aggravation of symptoms existing prior to treatment.

I understand that no guarantee is made concerning the use and effect of this treatment has been given to me and that I may stop treatment at any time.

I understand that Five Element treatment does not preclude the administration to me of conventional medical therapy by a licensed physician of same when in her/his discretion such therapy is deemed appropriate.

I agree to inform my Acupuncture practitioner of any and all other forms of treatment that I am now undergoing or considering including allopathic, naturopathic, chiropractic, homeopathic, dietary, herbal, massage, and other forms of energetic balancing, and/or dental work.

I understand that a record will be kept of the services provided to me. This record will be kept confidential and will not be released to others unless directed by myself or my representative or if required by law.

I agree to make arrangements for payment at the time of services received. For cancellation less than 24 hours prior to appointment, full fee will be due.

I certify that all questions I have asked concerning this consent form have been answered before signing.

Signature of Patient _____ Date _____

If not signed by patient, please indicate relationship to patient (e.g., mother) and patient's name.

Signature of
Parent/Legal Guardian _____ Date _____

Your Health Information Rights

You have the right to request restrictions on certain uses and disclosures of your health information. If services are paid in full by cash you may restrict that information to any insurer for purposes other than for treatment.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

You have a right to request that we amend your protected health information. Please be advised, however, that we may not be required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

- You have a right to receive an accounting of disclosures of your protected health information made by Loran Scruggs Lac
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

This office reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

Acknowledgment of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices for the office of (Doctors Name), detailing how my information may be used and disclosed as permitted under federal and state law.

Signature of Patient _____ Date _____

If not signed by patient, please indicate relationship to patient (e.g., mother) and patient's name.

Signature of
Parent/Legal Guardian _____ Date _____

Insurance Release of Information

I would like to take a moment to welcome you to my office and assure you that you will receive the very best of care available for your condition. In order to familiarize you with the financial policy of this office I would like to explain how your medical bills will be handled.

Explanation of Insurance Coverage:
Many insurance policies do cover acupuncture care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for acupuncture care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner.

Payment Arrangements
We require that you pay $20 towards today's charges and $20 on each visit.
If you have a specific contracted amount for co-payment that amount is due on each visit.

Assignment of Benefits
By signing this form you are authorizing payment of medical benefits will be made directly to this office. If your insurance carrier sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt. However if you pay for your visits in full the assignment will not be reported by this provider and any payment will be sent directly to you.

Release of Information
By signing this form you are also authorizing this office upon request from your insurance carrier the release of any medical or other information necessary to process the claim. You also acknowledge and request payment of government benefits either to myself or to the party who accepts assignment, namely this office.

Voluntary Termination of Care
If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately will be personally responsible for payment regardless of your insurance coverage.

We hope this answers any questions you might have concerning the financial policy of this office. Once again we welcome your to our office, and will be glad to answer any further questions that you might have.

I have read and agree to the above.

Signature_____ **Date**_____

Insurer _____**ID#** _____ **Date of Birth** _____

Phone Number _____ **Group#**_____ **Plan Name** _____

Insurance Mailing Address_____

Acupuncture coverage _____**Treatments/Limits**_____

Deductible _____