Authorization and Release Agreement Form

I hereby agree to pay my account as services are provided. If for any reason there is a balance owing on my account, I agree to pay promptly upon receipt of a monthly statement.

To avoid any complications, we ask that you first call your insurance company to ask if your policy pays for your specific acupuncture treatments covered by Licensed Acupuncturist.

The clinic staff will gladly help you file your insurance, but you are solely responsible for submission. Our office does not accept any co-pays from any type of insurance.

Cancellation Policy

Due to the nature of the services we provide we ask that if you will be late, 15 minutes or more for any appointment, please call our office before arrival to make sure the space will be available for you to receive a treatment.

By signing below, you agree to give our clinic 24 hour notice for cancellations. Any excessive cancellations or no show may result in a fee.

By signing below, you hereby agree that you have read all the contents of this page thoroughly; you understand all the possible risk factors and authorize treatment by our facility. If you do not understand or have questions about the information above, please feel free to speak with one of our assistants.

Signature_____ Date_____