# Eva Stanley Acupuncture

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## Consent for Care, Financial Policy Agreement, and Privacy Practices Acknowledgment

**Consent for Care:** I, the undersigned, in consideration of Eva Stanley Acupuncture's services, agree to following terms:

I hereby grant permission to Eva Stanley Acupuncture and its clinicians to perform examinations and therapeutic treatments as are considered necessary or advised for my diagnosis and treatment plan. Clinicians who treat me include, but are not limited to: medical doctors, acupuncturists, massage therapists, herbalists, nutritionists, physical therapists, rolfers, and/or chiropractors. My signature on this document serves as my consent for treatment.

**Authorization to Release Information for Insurance Clients:** I authorize Eva Stanley Acupuncture to release any information required to process a claim to any insurance company or attorney. I also authorize any insurance company or medical provider to release my medical records to Eva Stanley Acupuncture to process my claim for benefits due. I hereby agree that a photocopy of this document is as valid and effective as the original copy.

I understand Eva Stanley Acupuncture does not accept or bill insurance companies.

**Personal Responsibility for my Charges:** I understand that I remain personally responsible for my charges, and that at any time I can request a copy of my total charges from the office. I agree to pay in full amount of my charges to the office upon their demand. Any partial payments toward my charges shall not be acceptance of any installment payment plan, and shall not constitute a waiver of Eva Stanley's right to receive payment in full upon demand. In the event that any payer denies payment or claim by an insurance company or second party, I agree that I am personally, fully, and immediately responsible for the portion of my charges denied or likely to be denied. In no event shall I hold Eva Stanley Acupuncture liable in any of the above named instances.

**HIPAA Notice of Privacy Practices:** I understand I have access to the Notice of Privacy Practices and am able to review it and obtain a copy at my request.

☑ **Liability Agreement: I have read, understood, and agree to the terms of this agreement.**

☑ **I Agree:** ***Cancellation Policy: I agree to give 48 hours notice if I need to cancel an appointment. I understand that if I fail to give 48 hours notice on more than one occasion, I will be charged 100% of the scheduled appointment fee.***

**Patient Name**

**Patient Signature** **Date**

**Name Parent/ Legal Guardian**

**Parent/ Legal Guradian Signature** **Date**