

Holistic Kid.com
Emily Bartlett, LAc
Office Policies and Procedures
12114 Venice Blvd. Los Angeles, CA 90066
310.943.9044

Patient's Name: _____

Informed Consent

Acupuncture is an ancient healing art, recognized and relied on its simplicity and effectiveness for thousands of years. The statements listed below will assist your understanding and participation in the treatment process.

- Acupuncture is a technique utilizing tiny stainless steel needles inserted at specific points in the body in order to correct various ailments and stimulate the flow of vital energy. The location and depth of their insertion is determined by the nature of the patient's condition. I understand that the application of these needles may be accompanied by some painful sensations, and the rare possibility of bruising. From the standpoint of Oriental Medicine, these indications are not incompatible with effective treatment.
- Acupuncture therapy also includes the use of indirectly applying heat supplied by the burning of the herb Folium Artimesiae Vulgaris, commonly known as Mugwort. This process is known as "moxibustion."
- On rare occasions, patients have experienced faintness or nausea during an acupuncture treatment. This can be easily remedied and I will advise the Acupuncturist of these sensations.
- Acupuncture is not advised when the patient is too hungry, too full, or under the influence of drugs and/or alcohol. I understand that it is my responsibility to advise the Acupuncturist of these circumstances.

Initial _____ Initial _____

**Please initial here and sign the last page to indicate you have read and accept the terms of this section.
If patient is a minor, both parents and/or all legal guardians must initial and sign.**

Payment and Insurance

- Payment for treatment is expected after services are rendered. Payment and/or pre-payment of service is non-refundable regardless of treatment outcome.
- I will be provided with a super bill upon my request; it is my responsibility to submit this to my insurance, and complete any necessary follow-up with the insurance company for reimbursement.

Initial _____ Initial _____

**Please initial here and sign the last page to indicate you have read and accept the terms of this section.
If patient is a minor, both parents and/or all legal guardians must initial and sign.**

Cancellation Policy

I understand that I am expected to keep all my appointments as scheduled in order to ensure maximum progress in my, or my child's, treatment. I understand that the practitioner's time is reserved exclusively for my, or my child's, care for the duration of all scheduled visits, and that if I am late for my visit, the visit will end at the scheduled time and I will still be charged for the full visit time. If for some reason I cannot make an appointment, I will call at least **2 business days in advance** to cancel or reschedule that visit. I understand that if I cancel an appointment **less than 2 business days** prior to the scheduled time, I will be charged a fee that represents 50% of the cost of my scheduled appointment. I further understand that if I cancel **less than 1 business day** before my appointment, or fail to show for my appointment, I will be charged a fee that represents the full cost of my scheduled appointment.

Initial _____ Initial _____

Please initial here and sign the last page to indicate you have read and accept the terms of this section.

If patient is a minor, both parents and/or all legal guardians must initial and sign.

Authorization for Payment

I hereby authorize The Sanctuary Family Wellness Center to charge my account balance to the credit card indicated below. I authorize this credit card to be used as a guarantee against late cancellations and missed appointments, and for any and all balances including those relating to office visits, telephone/e-mail consultations, missed/late appointments, miscellaneous fees, and charges for nutritional supplements. I agree that if my credit card does not accept the charge, I will immediately make payment to The Sanctuary Family Wellness Center for the amount due. I understand that I may cancel this authorization in writing at any time.

Visa/MC (circle type) #: _____ **Exp Date:** _____ **Security Code:** _____

Authorized signature: _____

Telephone/E-mail Policy

I understand that extended telephone consultations over 10 minutes, will be billed at the same consultation rate as in-person visits and charged to my credit card on file.

I further understand that e-mails which take over 10 minutes to read and reply will be billed at the in-person consultation rate and charged to my credit card on file. By sending an e-mail, I acknowledge and agree that a prompt reply is NOT required, expected, or contemplated. I acknowledge that I will not use e-mail communication to deal with emergencies or other time-sensitive issues. I understand that e-mail communications may not be secure and that there is some possibility that confidentiality of such communications may be breached by a third party. I understand that The Sanctuary Family Wellness Center may keep copies of e-mail communications and that such messages may be included in your, or your child's, medical record.

Initial _____ **Initial** _____

Please initial here and sign the last page to indicate you have read and accept the terms of this section.

If patient is a minor, both parents and/or all legal guardians must initial and sign.

Notice of Privacy Practices

Questions and Complaints

If you have any questions about the Notice of Privacy Practices, please contact:

The Sanctuary Birth & Family Wellness Center: Privacy Officer, 11965 Venice Blvd. Suite 204 Los Angeles, CA 90066

If you think that we may have violated your privacy rights, contact the person named above. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will not retaliate in any way should you choose to file a complaint.

Initial _____ **Initial** _____

Please initial here and sign the last page to acknowledge that you have received, reviewed, and agree to the Notice of Privacy Practices. If patient is a minor, both parents and/or all legal guardians must initial and sign.

I have read and understand all of the contents in this document and agree to all of the terms listed above.

Printed Name: _____

Date: _____

Signature _____

Date: _____