ROCKY COAST
FAMILY ACUPUNCTURE

FINANCIAL AGREEMENT

CANCELLATION POLICY

It is important that you appear for all scheduled appointments and/or reschedule them in a timely manner of 24 hours from the time of your appointment. Your failure to do so, deprives other patients of an opportunity to visit our office. **Our cancellation policy is as follows:**

1. Your first failure to appear for a scheduled appointment or provide a minimum of 24 hours notice, you will be given a warning.
2. Your second failure to appear for a scheduled appointment or provide a minimum of 24 hours notice, you will be charged a fee of $50.00.
3. Your third failure to appear for a scheduled appointment or provide a minimum of 24 hours notice, you will be charged a fee of $85.00 and we reserve the right to discharge you from our practice.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I have read, understand and agree to adhere to the cancellation policy stated above.

Signature: _____ Date: _____

PAYER SCENARIO

☐ Referred by the VA SSN:_____-_____-_____

☐ I plan to pay the out of pocket, cash rate of $125.00 at the initial appointment, $85.00 at time of follow ups, and/or $45.00 at the Saturday Clinic. I understand that these charges are due at the day of service. I understand that if I plan to bill insurance but have not completed the process below, this payer scenario will apply until I have done so.

Signature:_____ Date:_____

☐ I plan to bill insurance for my visits. I understand that I am financially responsible for any services that my insurance company does not cover, denies, or processes and transfers to patient responsibility, (copay, amount billed towards deductible, etc.). I demonstrate my understanding of coverage by having completed the required phone call process below.

Subscriber Name:_____ **DOB:**_____ **Relationship:**_____

Date of Call:_____ **Reference # of Call:** _____

Do I have acupuncture coverage? ***Yes*** **or** ***No*** **Number of Visits Allowed:**_____

Do I have to meet a deductible prior to my coverage? ***Yes*** **or** ***No*** **Amount: $** _____

Have I met my deductible? ***Yes*** **or** ***No*** **Current Deductible Amount: $** _____

What is my copay? _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process claims. I understand that I am financially responsible for all services that I receive from provider. I authorize payment of medical benefits to the undersigned provider for services that I receive.

Signature_____ Date_____

Please inquire in our office for cards on file.

ROCKY COAST FAMILY ACUPUNCTURE

NOTICE OF PRIVACY PRACTICES

Understanding your health records: A record is made each time you visit Rocky Coast Family Acupuncture. Your symptoms, the practitioner's judgments, and a plan of treatment are recorded. This record serves as a basis for planning your care and treatment at future visits and serves as a means of communication among other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will assist you to ensure it is accurate and make informed decisions about who, what, where, when, and why others may be allowed access to your health information.

Understanding your health information rights: Your health record is in the physical property of Rocky Coast Family Acupuncture, but the content is about you, and therefore belongs to you. You have the right to review or obtain a paper copy of your health record, and request the appropriate amendments be made to your health record. You have the right to request restrictions on certain uses and disclosures of your information, to authorize disclosure of your record to others, and be given an account of these disclosures. Other than activity that has already occurred, you may revoke any further authorization to use or disclose your health information. Should we need to contact you, you have the right to request communication by alternate means or to alternate locations.

Our responsibility: Rocky Coast Family Acupuncture is required to maintain the privacy of your health information and to provide you with this notice of our privacy practices. We are required to follow the terms of this notice and to notify if we are unable to grant your request to disclose or restrict disclosure of your health information to others. Rocky Coast Family Acupuncture reserves the right to change our practices and promises to make a good faith effort to notify you of any changes. Other than for the reasons described in this notice, Rocky Coast Family Acupuncture, agrees not to use or disclose your health information without your authorization.

TO RECEIVE ADDITIONAL INFORMATION OR REPORT A PROBLEM, you may contact Jason S. Stein L.Ac. M.Ac. or Dawn Doiron, Office Manager. If you believe your privacy rights have been violated, you have the right to file a complaint with us and/or with the U.S. Secretary of Health and Human Services with no fear of retaliation by this office.
I, _____, have received a copy of this Notice of Privacy Practices. I understand my health information will be used and disclosed consistent with this notice.

ASSIGNMENT OF INSURANCE BENEFITS / RELEASE OF INFORMATION / PAYMENT AGREEMENT

I authorize and direct that payments be made directly to: Rocky Coast Family Acupuncture, 210 Western Avenue South Portland, ME 04106 for any and all insurance benefits or reimbursement for services rendered by Jason S. Stein L.Ac. M.Ac., Beth Herzig L.Ac. M.Ac., Leah Chamberlin L.Ac. M.Ac., Sarah Belisle Ph.d., L,Ac. and/or Matthew Brown L.Ac. MAOM, which amounts would otherwise be payable to me under any insurance or pre-paid health care plan.

I authorize the release of any information concerning my health and health care services to my insurance companies or pre-paid health care plan.

Rocky Coast Family Acupuncture will gladly bill your insurance on your behalf and make reasonable efforts to collect from that company. I understand that there is no guarantee that my insurance company or pre-paid health care plan will cover or pay for all my charges. Notwithstanding denial, reduction of benefits, or failure to pay for any reason, I understand that I am responsible for all remaining charges.

_____ _____

Signature of Client Date Signature of Person Authorized to Consent Date

CONSENT FOR TRADITIONAL METHODS

I, the undersigned hereby authorize (Jason S. Stein, Beth Herzig, Chris Haskell, and/or Leah Chamberlin) who are nationally certified by the NCCAOM and are currently licensed in the State of Maine to perform the following acupuncture procedures:

Acupuncture: the insertion of special sterilized, disposable needles through the skin into the underlying tissues at specific points on the surface of the body
Cupping: a technique used to relieve symptoms by applying cups made of glass, bamboo, or other materials to the skin with a vacuum created by heat or other devices.
Gua Sha: the rubbing of an area of the body with a blunt-edged instrument
Moxabustion (Moxa): the burning of herbs on or near the body to warm it, strengthens it, and relieves symptoms. Moxa comes in several forms such as a stick, string, ball, cone, or rice grain.
Dietary Advice: food and herbal advice based on traditional Chinese medical theory.
Electro-Acupuncture: the running of very low electrical current through one or more needles to help heal the body
Sonopuncture: the use of tuning forks to help heal the body with sound waves and vibration. The forks are placed near and on the body, often on acupuncture points and energy meridians.
I recognize the potential risk and benefit of these procedures as described below:
Potential risks: Although uncommon, there is a potential for acupuncture to produce some discomfort or pain at needled sites, minor bruising, or infection. It may also cause needle sickness, a broken needle, temporary discoloration of the skin, and potentially... an aggravation of symptoms existing prior to the acupuncture treatment. Clients with severe bleeding disorders or pacemakers should inform their practitioners prior to treatment.
Potential benefits: drugless or drug-reduced relief of presenting symptoms and the improved balance of bodily energies which may lead to prevention or elimination of the client's main complaint(s).

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Rocky Coast Family Acupuncture and its' providers regarding the cure or improvement of my condition(s). I hereby release Rocky Coast Family Acupuncture and its' providers from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and to discontinue participating in these procedures at any time.

_____ _____

Signature of Client Date Signature of Person Authorized to Consent Date

ROCKY COAST
FAMILY ACUPUNCTURE

PATIENT DEMOGRAPHICS & HEALTH HISTORY

No information contained herein will be released to third parties without your expressed consent.

Given Name: _____ **DOB:** _____

Preferred Name:_____ **Pronouns:** _____

Address: _____

City, State, Zip: _____

Home #: ( ) **Work #: ( )** **Cell #: ( )**

Occupation: _____ **Employer:** _____

Email: _____

Would you like to receive appointment reminder emails? ***Yes*** **or** ***No***

*EMAIL PRIVACY POLICY: WE DO NOT GIVE OUT EMAILS TO THIRD PARTIES.

Emergency Contact:_____ **Phone #: ( )** **Relationship:**_____

* PATIENTS UNDER 18 YEARS OF AGE, PLEASE PROVIDE NAME OF PERSON WHOM IS FINANCIALLY RESPONSIBLE.

How did you learn of RCFA?_____ May we thank this contact for your referral? ***Yes*** **or** ***No***

Have you had an acupuncture treatment before? ***YES***, **about**_____ **ago** **or** ***NO***

Please describe your heath goals, questions and/or concerns in seeking acupuncture:_____

_____

_____

_____

Current prescription or over the counter medications you take:_____

_____

_____

_____

Surgeries and/or hospitalizations with approximate dates:_____

_____

_____

_____

Allergies to Medications, foods, environmental: _____

_____

_____

_____

Major illnesses, accidents or traumas (physical and emotional) that we should be aware of:_____

_____

_____

_____

Check the O if **you** have been diagnosed with the following:

O Alcoholism/Drug Addictions
O Asthma/Lung Disease
O Bleeding Disorders
O Cancer
O Diabetes
O Epilepsy/Seizures
O Heart Disease
O High Blood Pressure
O Hepatitis/Liver Disease
O Kidney Disease
O Mental Illness
O Stroke
O Thyroid Disease
O Other

Do you exercise regularly? ***Yes*** **or** ***No*** If yes, how often?_____

Are you a tobacco smoker? ***Yes*** **or** ***No*** If yes, how often?_____

Are you a cannabis smoker? ***Yes*** **or** ***No*** If yes, how often?_____

Please describe what your typical food & drink intake is for the following:

Breakfast: _____

Lunch:_____

Dinner: _____

Snacks: _____

Please **check** the statements that you believe to be true for you:

__I am a creative/visionary person
__I am aware of lots of dreams
__I am healthier than I used to be
__I am less healthy than I used to be
__I feel well rested when I awaken
__I have difficulty falling asleep
__I have satisfying relationships
__I often feel irritable or angry
__I wake up often during the night
__I have a good balance between work
__I think of myself as powerful
__I feel well supported by others
__I take good care of others
__I feel appreciated
__I frequently feel fearful/cautious
__I have a good sense of humor
__I have experienced significant loss

Please **check any of the following** symptoms/statements you have experienced **in the past year**;
Please **circle any you are currently experiencing,** or would particularly like to discuss:

GENERAL
__Fatigue
__Fevers
__Night sweats
__Perspiration when not exercising
__Changes in memory
__Changes in mood

MUSCULOSKELETAL
__Neck pain
__Jaw pain (TMJ)
__Arm/shoulder/wrist pain
__Back pain
__Hip pain
__Leg/ankle/foot pain
__Joint stiffness
__Joint swelling
__Muscle spasm/stiffness

GASTRO-INTESTINAL
__Difficulty swallowing
__Nausea
__Vomiting
__Excessive belching/gas
__Indigestion
__Ulcers
__Abdominal pain
__Constipation
__Diarrhea
__Changes in bowel habits
__Blood in stool
__Hemorrhoids
__Change in appetite
__Gained/lost 10 lbs in 6 months

CARDIOVASCULAR
__Irregular heartbeat/palpitations
__Chest pain/tightness
__Pressure in chest
__High blood pressure
__Low blood pressure
__Varicose veins
__Blood clots
__Swelling of feet/ankle
__Cold hands/feet

GENITO - URINARY
_____Age at first menstrual period
_____Currently Pregnant
_____Date of last menstrual period
_____Date of last normal pap smear
_____Date of last GYN examination
__Regular menstrual cycle
__Irregular menstrual cycle
__Painful periods
__Heavy bleeding with periods
__Bleeding between periods
__Vaginal discharge
__Breast lumps
__Discharge from nipples
__Breast soreness before/ with periods
__Bloating before/with periods
__Mood changes before/with periods
__Endometriosis
__Ovarian cysts
__Infertility
__Challenges with breastfeeding
__Uterine prolapse
__Vaginal dryness
__Hot Flashes
__Number of pregnancies
__Number of children
__Generally satisfied with sexual life

SKIN
__Acne/pimples
__Eczema
__Other rashes
__Hives
__Itching
__Easy bruising
__New or changing mole

RESPIRATORY
__Shortness of breath
__Wheezing
__Dry cough
__Wet cough (phlegm)
__Coughing of blood
__Frequent colds

GENITO - URINARY
__Discharge from penis
__Lumps or swelling on testicle
__Infertility
__Generally satisfied with sexual life
__Use Contraception

HEAD/EYES/EARS/ NOSE/THROAT
__Dizzy spells/fainting/vertigo
__Frequent headaches
__Severe headaches
__Difficulty with vision
__Red/itchy eyes
__Dry eyes
__Difficulty hearing
__Ringing in ears __Nosebleeds
__Sinus infections
__Nasal congestion/runny nose __Mouth/lip sores
__Bad taste in mouth
__Sore throat
__Hoarseness of voice __Swollen glands

GENITO - URINARY
__Frequency of urination
__Pain or burning with urination
__Blood in urine
__Urinate more than 2 times a night
__Bladder/ Kidney infections
__Sexually transmitted diseases

Signature of Patient: _____ Date: _____

Signature of Reviewing Practitioner: _____ Date: _____