Intake Form

Paul Kerzner L.Ac.

Information provided on this form is confidential. It is very important the information given is complete and accurate to assist you properly in your healing process.

Please look for Above and Beyond Acupuncture on FB and join our online community for clinic announcements!

Today's Date ___/___/___

Name ____ Date of Birth ___/___/___ Age:________ Sex:

Address____

City/ State/ Zip ____ email _________________________________

Telephone: (home)__________________ (work)__________________ (cel) _________________________

Emergency Contact Person/Relationship____

Phone #___________________________

Who is your Primary Care Physician ? ____

Referrals are the best compliments. Whom may we thank for your referral ?

What are the concerns for which you are seeking care ? (symptoms, diagnosis and date of onset)

1. ____
2. ____
3. ____

What other treatments have you received for any of these conditions? _________________________________

What makes your condition better ? (movement, rest, heat, cold, eating, sleeping, crying, screaming,

etc)____

What makes your condition worse ? (fatigue, stress, certain foods or times of day, heat, cold, hunger, etc)

____

Significant Trauma, Hospitalizations, Surgery, X-Rays, Special Studies

Please include accidents, falls, illness as well as emotional along with month/year

____

____

Allergies

Are you hypersensitive or allergic to any foods, drugs, chemical or environmental substances ?

____

Medications and Supplements

What medications (prescribed or over the counter) herbs, vitamins, supplements, etc. are you currently taking ?

____

____

____

Check each that you currently use :

Laxatives Pain Relievers Antacids Cortisone

Antibiotics Heart/Blood medication Allergy Medication Thyroid medication

Sleeping Pills Anti-Depressants Birth Control Pills Hormones

Exercise, Energy and Dietary:

How much exercise per week______________Length of workout ________ Activities _____________________

How is your energy level ?_____________When is it lowest ?_________________Highest?_________________

Typical Diet

Meals per day # of Snacks Caffeinated Drinks Alcohol per week

Breakfast:____

Lunch:____

Dinner:____

Snacks:____

What foods are your weakness?____

Water intake per day ____________Prefer warm or cold drinks __________

Excessively thirsty ?_____

Special Diet :____

Personal History Please check any symptoms you have now or ever have had.

Cancer _____________________ Diabetes____________________ Seizures_______________

Heart Disease _______________ High/Low Blood Pressure__________ Stroke _______________

Anemia _____________________ Kidney Disease ______________ Hepatitis ______________

Thyroid Imbalance____________ Asthma _____________________ Eating Disorder________

Arthritis _____________________ Ulcer __________________ Alzheimers ____________

Auto Immune _______________ Alcohol/Drug Addiction_____________ Chronic Fatigue________

Blood Clotting Disorder_________ Prolapsed Organ ___________________ Chronic Pain ___________

Do you smoke ? (Tobacco or Marijuana) For how long ? ___________________ How much a day ?___________

Other serious Health Condition ____

Family Medical History Please check any condition that applies to your immediate family : (M) Mother, (F) Father, (S) Sister, (B) Brother, (GM) Grandmother, (GF) Grandfather

High Blood Pressure _____________ Diabetes____________________ Heart Disease_______________

Cancer _________________________ Stroke______________________ Asthma _____________________

Seizures _________________________ Genetic Disorder ______________ Infertility_____________________

Other Serious Condition ____

Have you had any of the following Childhood Illnesses (check if yes)

Scarlet Fever ___ Diptheria ____ Rheumatic Fever ____ Mumps _______ Measles ____ German Measles _____

Have you had negative reactions to immunizations ? Yes No ____

General

Height ____________ Weight ______________ lbs.

Weight one year ago ____________ lbs. Maximum Weight _________ lbs. When ______________

Blood Type _________________ Most recent blood pressure reading? _____ /______ Taken when?_________

Check any symptoms you currently experience and star ones you have had in the past

GENERAL	NOSE AND SINUSES	HEAD / NECK
____ Poor or Change in Appetite ____ Poor Sleep ____ Fatigue / Low Energy ____ Fevers ____ Chills ____ Cravings ____ Bleed/Bruise Easily ____ Night Sweats or Hot Flashes ____ Sweat Easily ____ Colder than those around you ____ Warmer than those around you ____ Weight loss or gain ____ Libido Low, Med or High ____ High Stress	____ Frequent Colds ____ Nose Bleeds ____ Sinus Congestion ____ Frequent Runny Nose ____ Hay Fever ____ Sinus Problems ____ Loss of Smell **IMMUNE** ____ Chronic Fatigue Syndrome ____ Chronic Infections ____ Chronically Swollen Glands ____ Slow Wound Healing	____ Headaches ____ Migraines ____ Jaw Pain ____ Teeth Grinding ____ Swollen Glands ____ Goiter ____ Recurrent Sore Throats/Colds
SKIN ____ Rashes ____ Eczema or Psoriasis ____ Acne, Boils ____ Redness of Skin ____ Itching ____ Fungal Infections ____ Skin Discoloration ____ Hair Loss ____ Dry Skin/Scalp ____ Greasy Hair ____ Change in Hair texture ____ Night Sweats ____ Slow healing ulcerations ____ Weak or ridged nails ____ Recent Moles	**MOUTH AND THROAT** ____ Sore Throat ____ Copious Saliva ____ Teeth Grinding ____ Sore Tongue/Lips ____ Gum Problems ____ Hoarseness **RESPIRATORY** ____ Chest Congestion ____ Chest Tightness ____ Asthma ____ Difficulty inhale/exhale ____ Phlegm...what color ? ____ Cough ___ Wet or ___ Dry ____ Coughing Blood ____ Bronchitis ____ Pneumonia	**NEUROLOGIC** ____ Seizures or Tremors ____ Paralysis ____ Muscle Weakness ____ Numbness or tingling ____ Easily Stressed ____ Vertigo or Dizziness ____ Loss of Balance **CARDIOVASCULAR** ____ Chest Pain or Pressure ____ Shortness of Breath ____ Irregular Heart Beat ____ Palpitations at Rest ____ Blood Clots ____ Irregular Heart Beat ____ Palpitations/ Fluttering ____ Swelling of Hands or Feet

EYES AND EARS

____ Itchy Eyes
____ Watery Eyes
____ Dry Eyes
____ Swollen/painful eyes
____ Red Eyes
____ Blurred Vision
____ Spots in Front of Eyes
____ Cataracts
____ Color Blindness
____ Double Vision
____ Glaucoma
____ Hearing Difficulty
____ Ringing
____ Earaches/ Infection

DIGESTION

____ Abdominal Pain/Cramps
____ Trouble Swallowing
____ Heartburn/Acid Reflux
____ Change in Appetite/Thirst
____ Nausea
____ Vomiting
____ Gas/Bloating
____ Belching or Passing Gas
____ Diarrhea
____ Constipation
____ Pain or Cramps
____ Mucous in Stools
____ Black/Bloody Stool
____ Hemorrhoids
____ Itchy/Burning Anus
____ Bad Breath
____ Strong Smelling Stools
____ Food in Stools
____ IBS
____ Crohns
Bowel Movements : How Often ? ___
Stools ___ Hard ___ Firm
___ Soft ___ Loose (> 2 / day)

CIRCULATION

____ Faintness
____ Dizziness
____ Easy Bleeding or Bruising
____ Anemia
____ Deep Leg Pain
_____ Varicose Veins
_____ Cold hands/feet
_____ Spontaneous Sweating

ENDOCRINE

_____ Hypothyroid
_____ Heat or Cold Intolerance
_____ Hypoglycemia
_____ Diabetes
_____ Excessive Thirst
_____ Excessive Hunger
_____ Seasonal Depression

MUSCLE / JOINT / BONES

____ Neck Pain
____ Jaw Pain
____ Shoulder Pain
____ Arm/Wrist Pain
____ Knee Pain
____ Back Pain: Low Middle Upper
____ Sciatica
____ Heaviness of Limbs
____ Muscle Pain/Tension
____ Muscle spasms / cramps
____ Restless Leg Syndrome
____ Weak/Sore Lower Body
____ Areas of Numbness
____ Loss of Strength
____ Tingling Sensations

GENITO-URINARY

____ Pain/Burning when urinating
____ Frequent Urination
____ Dark or Pale Yellow
____ Cloudy Urine
____ Night Urination
____ Copious or Scanty Urination
____ Inability to hold Urine
____ Urinary Tract Infections
____ Kidney Stones
____ Blood in Urine

MENTAL / EMOTIONAL

____ Mood Swings
____ Anxiety or Nervousness
____ Depression
____ Poor Concentration
____ Poor Memory
____ Angry Outbursts
____ Weepy
____ Sadness

FEMALE ONLY

____ Irregular Cycles
____ Bleeding between Cycles
____ Pain during Intercourse
____ Clotting
____ Heavy or Excessive Flow
____ PMS
____ Painful Menses
____ Vaginal Discharge ? Color ?
____ Vaginal Itching/Burning
____ Vaginal Odor
____ Menopausal Symptoms
____ Vaginal Dryness
____ Sexually Transmitted Disease
____ Breast Pain / Tenderness
____ Nipple Discharge
____ Breast Lumps
_____ Ovarian Cysts
_____ Endometriosis
_____ Uterine Fibroids/Polyps
_____ Polycystic Ovarian Syndrome
_____ Pelvic/Tubal Infection
_____ Pelvic Inflammatory Disease
_____ Pelvic Adhesions/Scarring
_____ Chlamydia
_____ Herpes
_____ Bacterial Vaginosis
_____ Genital Warts

Are you sexually active? Yes No
Do you practice Birth Control ? Type ?
____
Have you ever taken the Pill ?
Used an IUD ?

Number of Pregnancies ___________
Number of Live Births ____________
Number of Miscarriages ___________
Number of Abortions _____________
Number of Ectopic Pregnancies ____

Difficulty Conceiving _____________
Difficult or Premature Births _______
Do you do Breast Self Exams ?
Date of last PAP/Pelvic ___________
Abnormal PAP ? When ?

MALES ONLY

_____ Hernias
_____ Testicular Masses
_____ Testicular Pain
_____ Varicoceles
_____ STD
_____ Premature Ejaculation
_____ Prostate Disease
_____ Sexually Transmitted Disease
_____ Discharge or Sores
_____ Sexual Dysfunction

Are you sexually active ? Yes No
Birth Control ? Type?

_____ Infertility
_____ Semen Analysis Results ?

Muscles, Joints & Bones Continued :

Do you have pain or tightness? Where?_____________________________

Recent injuries? _________________ Was this from an auto accident or work related?____________________

The pain is (check all that apply): Sharp Dull Aching Numb

Superficial Pain Deep Pain Burning Tingling Shooting

Pain worse/better with heat Pain worse/better with cold Pain worse/better with pressure

Pain worse in am/pm Pain worse/better with movement

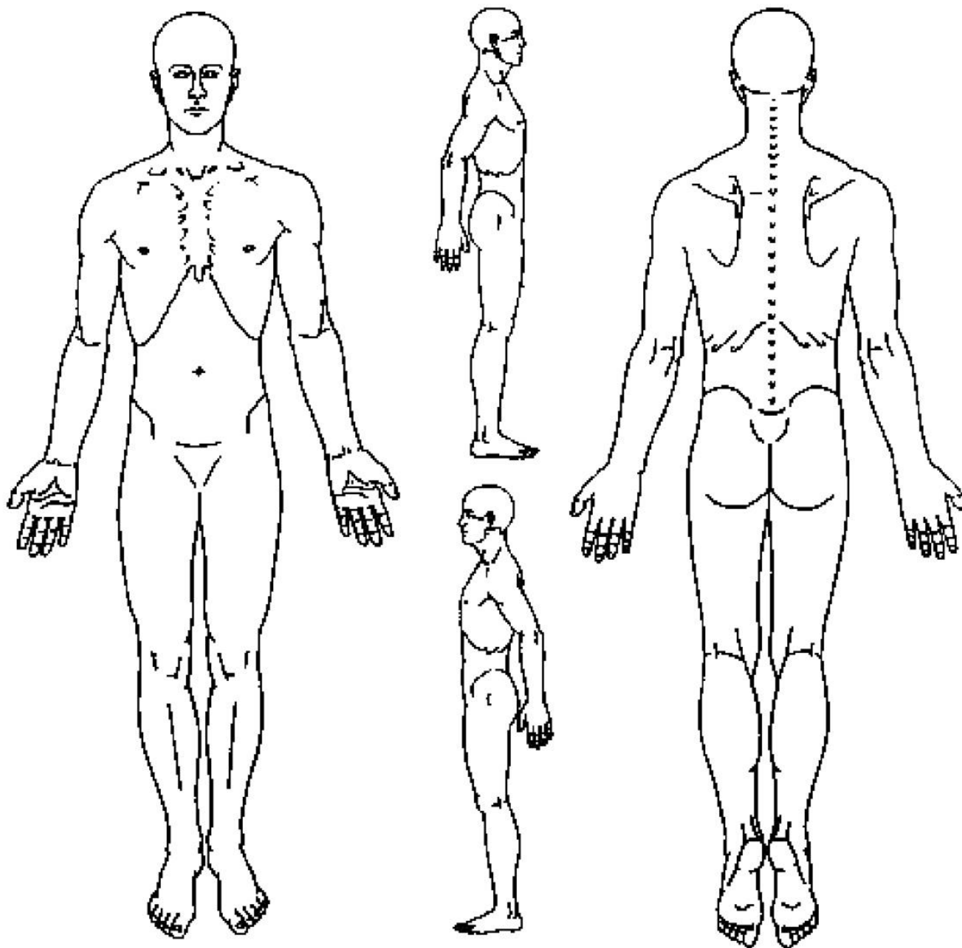
I have (check all that apply): Swollen joints Arthritis/joint pain Tendonitis

Bone pain Muscle cramping Muscle pain Repetitive Strain Injury

Fractured Bone(s) -- Where?________________

Other__________________

Pain Diagram (please mark all areas of pain on diagram below) A= aching B= burning N=numbness P= pins and needles
S= stabbing pain O= other type of sensation



Gynecological/Reproductive, continued

Attempting Pregnancy currently? If so, for how long? ________
Currently Pregnant If so, how far along ________ Currently breastfeeding If so, how long?________ Difficult scanty or painful lactation ______________
Post-partum difficulties________________
Describe____
Premature deliveries ________________ Difficult deliveries_________________
Describe____
Difficulties in Pregnancy
Describe____
____
____

Age of first menses__________ What was it like for you?____________________________________
Date of last menses_________ Recent menstrual changes If so, what ?_______________________
How many days do you normally bleed? ______ How many days between periods? _____
How heavy is the bleeding? Heavy Average Light How many pads/tampons per day?_________
What color is the blood? Pale red, pink Red Dark red Purple Brown Black
Is the blood Watery Clotted Mucousy Thick Strong odor

Painful periods If so, how many days does pain last? _______ What makes the pain better?_________ Heaviness or pressure in pelvis with periods
Have you ever gone more than 2 months without getting your period? When?_________
PMS What symptoms____________________________________ When do they start?_____________
Bleeding/Spotting between periods When in cycle _________________________
Do you ovulate regularly?______ If so, on what day of your cycle?_______ Is ovulation painful?____ Do you observe cervical mucus changes with ovulation?____________________________ Bleeding with ovulation?______
Do any of your symptoms seem to change or worsen around you period?
How?____________________ Menopausal Symptoms
Describe____
____
____

Sleep

How long do you normally sleep? ______________ hours per night
I have difficulties with (check all that apply): ____ Falling asleep _____ Staying asleep
____ Dream-disturbed sleep ________Waking up at about _____am/pm and not being able to fall back asleep

Emotional Health

Have you ever been treated for a psychological concern? Yes No
Have you experienced sexual or physical abuse? Yes No
Have you ever considered or attempted suicide? Yes No
Have you ever been treated for substance abuse? Yes No
Please rate your overall stress level. Low Medium High

Are you currently working with a counselor? If so, who?_______________________________________ If possible, please describe the most challenging emotion you experience__________________________
When do you most often feel this emotion?____
What experiences or activities bring you the most joy and nourishment?__________________________
____
What goals do you have for your acupuncture treatments?______________________________________
____

Comments: Please describe anything else you would like to discuss. ______________________________
____

HIPPA Notice
Privacy Disclosure and Policies

As a patient at this clinic, you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the methods in which your information is secured confidentially in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). This notice describes the policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

Safeguards in place include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Public Interaction

Should we see you socially, by coincidence or intent, we will not acknowledge how we are acquainted unless you infer consent through introduction, etc.. It is our preference to discuss your health in the office setting only to protect you privacy and ensure that important information is kept in your chart.

Consultations

We consult with other healthcare practitioners and clinical specialists while working on patient cases and treatment plans. These conversations and transfers of information by phone, in person, by fax, or email are confidential, and names are not used unless necessary and consent is provided from you either verbally or in writing. In administering your health care, we may gather and maintain information that may include these examples of non-public personal information

- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third party administrators (e.g. requests for medical records, claim payment information)

Records Release

Your confidential healthcare information is private and cannot be copied and shared with anyone else without your written, signed consent. In some cases, if time does not permit, your verbal approval may be accepted after proper identification is acquired. Copies of released records are sent by mail or fax, and are accompanied by a Confidential Patient Information Cover Sheet if faxed.

Definition and Penalties to Comply

Protected health information is any information, whether oral or recorded, in any form or medium that: 1) is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearing house in the normal course of business, and 2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual. This information may reside in any medium: tape, paper, disc, fax, email, and/or digital voice message.

I have read and understand my right to privacy, as stated above, and agree to have Paul Kerzner, Licensed Acupuncturist maintain my records confidentially in accordance with the law. I agree to inform Paul Kerzner, Licensed Acupuncturist if I need any special arrangements pertaining to this issue.

signature	date
print name	

Informed Consent to Receive Treatment

By signing below, I do hereby request and voluntarily consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named above and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine , nutritional counseling and lifestyle coaching.

Acupuncture: This is a safe treatment involving the insertion of fine sterile and single use needles through the skin. Treatments can occasionally produce a mild but temporary discomfort, usually achiness, tingling or soreness at the acupuncture site. Treatments can also cause slight bleeding and will rarely leave a non-painful bruise at the acupuncture site. Other possible risks from acupuncture include dizziness and fainting. I agree to come to each session having eaten within the past 3 hours, and I will report to my Licensed Acupuncturist any dizziness or light-headedness that occurs during or after an acupuncture treatment. Extremely rare risks of acupuncture include nerve damage, organ puncture and infection. These risks have an extremely low incidence, especially when acupuncture is administered properly by a Licensed Acupuncturist.

Traditional Chinese Herbal Medicine Treatments: Chinese herbs have been used safely for centuries. Infrequently, one may experience digestive upset or other reactions to herbs. If I experience any discomforts related to the use of any herbs I am prescribed, I understand that I should stop the herbs and that I am responsible for informing my Licensed Acupuncturist of my symptoms. Some herbs may be inappropriate during pregnancy or breastfeeding. I accept full responsibility to inform my practitioner immediately if I am pregnant or breastfeeding, or if I am attempting or suspecting pregnancy. With all herbal treatment, I agree to follow the prescribed dosage and administration guidelines given to me by my acupuncturist. I will inform my practitioner if I am taking any medications, or if there are any changes in my medications, before any herbal treatment is initiated.

Heat Treatments with Moxa or a TDP Lamp: These methods are used to warm areas of the body to promote health. Every precaution is taken to prevent over-warming, but the rare possibility of mild burns exists.

Cupping: This technique involves a localized suction produced by heating a small glass cup. There is a possibility of local non-painful bruising from this suction. Very rarely a slight burn or blister may appear due to the heat.

Gua Sha: Gua Sha is light scraping on the skin in a small area using a smooth-edged instrument. This often results in bruising of the treated area. The bruising, which is not painful, usually resolves in 3-7 days.

Electro-Acupuncture: A mild electric micro-current similar to a TENS treatment may be used to stimulate the acupuncture points. A mild tingling or tapping sensation will be felt during treatments. Occasionally a mild achiness or soreness will be felt at the areas treated for up to a day after the treatment. I understand that I must inform my practitioner if I am using a pace maker or have any heart or neurological condition prior to having this treatment.

Acupressure and Massage: Acupressure and massage are used to reduce or prevent pain, and to normalize the body's physiological functions. I will inform my Licensed Acupuncturist of any areas of injury or extreme discomfort, as well as any areas where I have had surgery, prior to any massage. I understand that there may be muscle soreness or achiness as well as the possible aggravation of symptoms existing prior to the treatment during or after massage.

I understand the clinical and administrative staff may review my patient records and lab records but all my records will be kept confidential and will not be released without my written consent. By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present conditions and for any future condition(s) for which I seek treatment.

Patients who are pregnant, have a pacemaker or heart condition, have a seizure disorder, or those with a bleeding disorder or taking blood thinners should discuss this with the acupuncturist before proceeding with acupuncture.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician, as Paul Kerzner, LAc is not primary care physicians.

I have read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

signature	date
print name	

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care proviser, including those working at the health care provider's clinic or office or any other office whether signatories this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with the reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example), emergency treatment) patient should initial here. ________. Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL PRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE X (Date)

(Or Patient Representative) (Indicate relationship if signing for patient)

OFFICE SIGNATURE X (Date)

FINANCIAL & OFFICE POLICIES

Above & Beyond Acupuncture practitioners request payment for your treatment at the time of service. Cash or check payments are preferred but we also take VISA, MasterCard and Discover.

Electronic Communication: At times, Above & Beyond Acupuncture uses email and text message to correspond with patients as a convenience. However, these forms of communication are not encrypted and could theoretically be read by an outside party with the technical skills to intercept such correspondences. By initialing this section, you consent to allow Above & Beyond Acupuncture to correspond with you electronically despite these potential risks. Initial ______

Returned Checks: If your check is returned for insufficient funds, there will be a $25.00 Returned Check fee added to your account, in addition to the amount the check was for. Initial ______

Nonpayment: If your account is over 90 days past due from our first billing sent to you, it will be referred to a collection agency for payment. By signing this agreement you will also authorize the office to release information needed to secure payment. Initial ______

Missed Appointments: If you miss your appointment or cancel with less than 24 hours notice, you will be charged for the appointment. Initial _______

I have read and understand the policies and agree to abide by the guidelines.

___________________________________ ___________________

Signature of patient or responsible party Date

Thank you for understanding our policies. Please let us know if you have any questions.