Alpine Acupuncture, LLC
628 NW York Drive, Suite 104
Bend, Oregon 97701
(541) 330-8283

Steven A. Foster-Wexler, LAc
State License #AC00762
Tax ID# 20-0452417

OFFICE PROCEDURES

Please read carefully and then acknowledge your understanding by signing where indicated. If you need clarification or have any questions please ask.

APPOINTMENT SCHEDULING:

Our commitment is to address the cause of illness rather than to treat the symptoms alone. In order to identify the cause(s) of your condition, the practitioner will conduct a consultation, examination, and any other indicated assessments. If at the end of your evaluation the practitioner feels you will respond favorably to treatment, he will prescribe a course of care that can include a combination of educational materials, specific therapies, consultations, and then subsequent re-evaluation and re-examination.

These reassessments and re-examinations are crucial to the practitioner's ongoing evaluation of your response to the prescribed program. They are necessary to help distinguish whether changes in your treatment plan are needed. Remember that symptoms may resolve long before the underlying causes of disease have been eliminated completely. Our aim is to support you in eliminating the cause of any condition.

APPOINTMENT CHANGES:

We require a minimum of 24 hours advance notice in order to reschedule an appointment. We reserve the right to charge for patients who neglect to reschedule 24 hours in advance.

PAYMENT OF SERVICES:

Payment is due at the time of service unless arrangements are made in advance. We accept Visa, MasterCard, personal check, or cash.

We have found this policy to be most effective for both patients and providers. Outstanding balances can cause embarrassment and communication breakdowns, and potentially decrease adherence to the prescribed treatment program. If you foresee any financial challenges, be sure to address them with us prior to your appointment.

I have read, understand, and agree to the above statement regarding responsibility for my health care and payment policy.

_____ _____

Signature of Patient or Legal Guardian *Date*

INSURANCE RELEASE AND ASSIGNMENT

I agree to be financially responsible for all charges incurred at this office, including my insurance deductible, co-payment and any services rejected by my insurance company.

I authorize this office to release any information that is required or necessary for my claim to any insurance company, adjuster, or attorney involved in this case; and hereby release this office of any consequence thereof.

I hereby instruct and direct my insurance company to pay by check, made out and mailed directly to this office, the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this office.

I give this office power of attorney to endorse checks made out to me, to be credited to my account.

_____ _____

Signature of Patient or Legal Guardian *Date*