3712 MacArthur Blvd. Ste 208
New Orleans, LA 70114
(504) 362 - 8020
info@nolaacupuncture.com
www.nolaacupuncture.com

5150 Highway 22, Suite A6
Mandeville, LA 70471
(985) 635 - 8846
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Acupuncture Wellness Center Policies

Welcome to Acupuncture Wellness Center. Acupuncture Wellness Center is an integrated healthcare, well-being and longevity center. Combined with modern Western medical consultation, we provide full scale traditional Chinese medical techniques including acupuncture, herbal medicine, dietary recommendations, and life style modification. All services are provided by Louisiana State licensed and National Certification Commission of Acupuncture and Oriental Medicine (NCCAOM) certified acupuncturists.

We emphasize a patient's total health and well-being. We view each patient as an individual whose well-being is affected by lifestyle, diet, emotions, attitude and environment. Thus we provide a very personalized, holistic, and preventive healthcare service. We not only treat the current condition, but also look for the underlying causes and improve a patient's general well-being and happiness.

We are delighted to have you as a new patient and look forward to providing you with the highest quality care. In order to serve your needs efficiently, we have a few guidelines. Please take a minute to carefully read and sign the following forms and bring with you to your initial appointment.

APPOINTMENTS AND SCHEDULING

Treatments are by appointment only. Occasionally, however, emergency appointments are available if there is time in the schedule. To make an appointment, please call us at 504-362-8020 (New Orleans) or 985-635-8846 (Mandeville). Please be on time for appointments. Your prompt arrival for scheduled appointments will help us run smoothly. Unfortunately, because schedules are often tight, you may receive a shortened treatment or need to be rescheduled if you arrive late. You will still be responsible for the visit fee. Lateness will be treated in the same manner as missed appointment, as indicated below. However, if we are running late, you will always receive a full treatment.

FEES AND BILLING

New Patient Visit	$ 95	5 Visit Package	$ 300
Return Visit	$ 75	10 Visit Package	$ 550
Community Clinic	$ 40	NADA Special (smoking cessation)	$ 20

* The first visit for Community Clinic and NADA Special are also $95 for two hours of comprehensive medical history intake and an acupuncture treatment.
** ‘5 or 10 Visit Package’ are granted for certain circumstances that will require multiple treatments in a short span of time. Conditions do apply. Any unused treatments purchased with a Treatment Package will be retained on file as credit towards future treatments.
*** Herbal supplements are not included. The cost for herbal supplements varies depending on the type of formula and individual ingredients used in your formula.

Payment for all services and products are due at the time of the visit, unless appointments have been pre-paid for Treatment Packages. Payment can be made by cash, personal checks, Visa, or MasterCard. Returned checks are subject to a $25 service charge.

HEALTH INSURANCE

At this time, acupuncture is not a reimbursable expense in Louisiana. We do not bill insurance companies for you and payment is due at the time of service. After you visit we will gladly provide you a receipt containing the appropriate codes that your insurance company would need if they will reimburse you directly according to your policy. Acupuncture Wellness Center is considered a 'provider' by various health insurance companies which entitle the members of those company's policies to a discount on our fees. Please check your insurance company with us at the time of your visit.

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CANCELLATIONS

AT LEAST 24 HOURS NOTICE OF CANCELLATION IS REQUIRED TO AVOID $25.00 MISSED/LATE CANCELED APPOINTMENT CHARGE. Our time and expertise are what you essentially pay for. Occasionally there is a problem with patients who are not used to keeping on schedule themselves. In order to offer high quality health care to all patients, at least 24 hour notice for canceled or rescheduled appointments is required. All appointments that are rescheduled or cancelled with less than 24 hour advance notice, and appointments missed without notice, will be charged $25. If appointments have been pre-paid, the missed, cancelled or rescheduled appointment fee will be deducted from the patients balance. If you expect to be more that 15 minutes late, please call to confirm availability.

HERBAL PHARMACY

The outcome of an herbal consultation is a personalized prescription which will be filled at Acupuncture Wellness Center. We use high quality granular extracts produced by E-Feng Herbs and MayWay to create customized herbal formulas. The prices for herbal pharmacy vary depending on individual ingredients used in your herbal formula. For your convenience, we may put granular extracts into capsules. Additional fee of $0.05/capsule will be charged if you request your formula in capsules. All herbs must be paid in full at time of purchase. If your prescription was written for refills, simply call at least 24 hours before you would like to pick up your prescription.

THE INITIAL VISIT

Generally, your first visit will be the longest. Please be sure to have eaten within 2-3 hours of the visit and wear loose, comfortable clothing. We request that you come in at least 20 minutes early to complete information forms. This will also enable us to run on time.

MEDICATION/SUPPLEMENT LIST

Please provide us with a complete list of your recent and current medications with dosage, the supplements, and herbal or nutrient. If you possess any of your medical records, including past x-rays, lab work or other diagnostic studies, please bring those along.

COMMUNITY CLINIC

Acupuncture Wellness Center offers $40 community-style treatments on Saturdays from 9 am to 1 pm. (The first visit for Community Clinic is also $95 for two hours of comprehensive medical history intake and an acupuncture treatment.) Treatment will be provided in a community room shared with other patients at the same time. Patient health care information will be briefly discussed in low voices in the community room in order to respect privacy. In order to maintain calm and relaxing atmosphere in the community room, please turn off your cell phone before entering the room.

ACCEPTED AND AGREED BY:

I have read and understand the information enclosed. By my signature below, i acknowledge receipt of notice of privacy practices, and i give my voluntary consent for acupuncture wellness center to use and disclose my identifiable health information for purposes of treatment, payment (including benefit payment and for establishment of entitlements) and health care operations.

______________________	______________________	____________
Patient’s Name (Printed)	Patient’s Signature	Date
______________________	______________________	____________
Representative’s Name (Printed)	Representative’s Signature	Date

(Required if the patient is a minor or an adult who is unable to sign this form)

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including 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 a 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, as to whether this agreement is unconscionable, and any procedural disputes, 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 or 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, preceptors, or 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 provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to 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 the 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. This agreement is intended to create an open book account unless and until revoked.

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 incurred 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 a 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 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 of 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 MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

(Date)

PATIENT SIGNATURE **X**

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

(Date)

OFFICE SIGNATURE **X**

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ALSO **SIGN** THE **INFORMED CONSENT** ON **REVERSE** SIDE

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below 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 below 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, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, 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 condition and for any future condition(s) for which I seek treatment.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

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

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE