155 Main Dunstable Road, Suite 135
Nashua, NH 03060

Welcome! I look forward to helping you to meet your health goals. Please take a few minutes to fill out this questionnaire to help me to serve you better.

Name:_____ Date:_____
Address:_____
City/Town:_____ Zip Code:_____
Home Phone:_____ Cell Phone:_____
Work Phone:_____ E-mail address:_____
Best way to reach you:_____
Is it acceptable to leave a message at this number:_____
How would you like your appointment reminder? Phone_____ Text_____ Email_____
Would you like to be added to our mailing list? Yes_____ No_____
Would you like to be added to our e-mail list? Yes_____ No_____
If yes, you will receive an invitation to the email address provided. You must click "Subscribe" to receive newsletters.

How did you learn about our clinic and services?
Telephone book_____ Internet_____ if so, what site?_____
Doctor (please name)_____
Friend/personal referral (name, if desired)_____
Insurance provider list_____ Other_____

Acupuncture Center of Southern NH, LLC
155 Main Dunstable Road, Suite 135
Nashua, NH 03060

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 the patient named below for whom I am legally responsible) by the acupuncturist named below and/or licensed acupuncturists who now or in the future treat me while associated with or serving as a back-up for the acupuncturist named below.

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 acupuncture is generally a safe method of treatment, but that it may have some side effects. These side effects include bruising, numbness, or tingling near the needle sites that may last a few days, as well as dizziness and fainting. Burns and/or scarring are a potential risk of moxibustion, or when the 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, single-use needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects may occur. I will notify clinic staff if I am or become pregnant.

I do not expect the clinic 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 judgement during the course of treatment which the clinical staff thinks, at the time, based upon the facts known is in my best interest. I understand 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.

_____ _____
Patient signature Date

_____ _____
Office signature Date

Acupuncture Center of Southern NH, LLC
155 Main Dunstable Road, Suite 135
Nashua, NH 03060

Financial Policy

Payment is expected at time of visit. It may be made by cash, check, or credit card.
Acupuncture is a Flexible Spending Account or Health Savings Account eligible expense, and payment may be made via FSA/HSA account card with a Visa or MasterCard logo.

Insurance will be billed as applicable by this office, but you are ultimately responsible for payment for all services. Many insurance companies do cover acupuncture care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for acupuncture care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner.

If your level of coverage is uncertain we require that you pay $20 towards today's charges and $20 on each following visit. Your full portion of the bill is expected when payment is received from your insurance carrier. If you have a specific contracted amount for copayment that amount is due each visit.

Any unpaid balances will be considered past due 30 days following treatment or insurance reimbursement, which ever come last. Past due balances may have an interest charge of 1.5% applied per month.

By signing this form you are authorizing this office, upon request from your insurance carrier, the release of any medical or other information necessary to process the claim.

By signing this form you are authorizing payment of medical benefits be made directly to this office. If your insurance carrier sends payment to you for services incurred in this office you agree to send or bring those payments to this office upon receipt. However, if you pay for your visits in full the assignment will not be reported by this provider and any payment will be sent directly to you.

If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you ultimately will be personally responsible for payment regardless of your insurance coverage.

Your appointment time is reserved for you. If you cannot make your scheduled appointment, this office requests 24hrs notice. **Failure to provide such notice will result in a $35 late cancelation fee. A No Show/ No Call will result in a $50 fee.**

Your understanding is greatly appreciated.

I have read and agree to the above:

Printed Name : _____ Date: _____

Signature : _____ SSN: _____

Acupuncture Center of Southern NH, LLC
155 Main Dunstable Road, Suite 135
Nashua, NH 03060

Privacy Policy Acknowledgement

I have received, read, and understand the Notice of Privacy Policies of this clinic. I understand how this clinic may use or disclose my health information. I understand when this clinic may not use or disclose my health information. I understand my health information rights and understand that the office reserves the right to change the Notice of Privacy Policy. I also understand how to place a complaint regarding this Notice and have also been provided the opportunity to review and question the privacy policy of this clinic.

_____ _____
Signature of Authorized Person Date