



To the  
**New Patient**

Outline of Procedures for Care

**STEP ONE:** All new patients are requested to carefully read the included materials and fill out the personal health history questionnaire

**STEP TWO:** A one-on-one consultation will be done to discuss your health problems.

**STEP THREE:** An Oriental Medical examination-including classical pulse diagnosis and tongue diagnosis-will be given to determine the precise cause of your problem.

**STEP FOUR:** The Acupuncturist will advise you if additional tests are needed.

**STEP FIVE:** You will be given an initial Report of Findings at which time the cause of your problem will be discussed. It includes a thorough explanation of our treatment recommendations and what results can be obtained.

**STEP SIX:** If you are accepted as a patient, care will begin. Additional explanations will be given on the different types of treatments that are available in the office.

**STEP SEVEN:** An estimate of the future care that is needed will be given and upon your acceptance, care will continue until the personal maximum correction of your problem has been obtained.

**STEP EIGHT:** After maximum correction has been obtained, a schedule of care will be recommended to help prevent future problems and maintain good health.



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Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Acupuncturist will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Relief Care
- Corrective Care
- I want the Acupuncturist to select the type of care of appropriate for my condition

Date \_\_\_\_\_ Patient's Signature \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Acupuncturist's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Acupuncturist's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if, I suspend or terminate care, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorized the Acupuncturist's to treat my condition as s/he deems appropriate. I also agree that I am responsible for all bills incurred at his office.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Consent to Treat a Minor \_\_\_\_\_ Date \_\_\_\_\_

Guardian or Spouse's  
Signature Authorizing Care \_\_\_\_\_ Date \_\_\_\_\_



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**PRIVACY PRACTICES ACKNOWLEDGEMENT FORM**

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name:	Date of Birth:
Signature:	
Date:	



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## Natural Approach Wellness Center Office Policies

We would like to take this opportunity to inform you of our payment policy. The overwhelming majority of our patients pay their bills when services are rendered, as this is our policy. In the past we have occasionally accepted the delays in payment, but the economic environment compels us to introduce measures to ensure that all payments are received on time.

1. Payment is expected at the time of service.

*(Note: if you are one in treatment plan, payment is expected on exact date agreed upon)*

2. If you are a Personal Injury (PIP) case and your benefits exhaust, we will collect a \$35.00 co-pay for each visit to reduce the amount owed to our office after case settlement.
3. There will be a \$25.00 service charge or 5% of the face amount of a check returned. Whichever is greater.
4. Please keep in mind there will be a \$35 fee on the 2<sup>nd</sup> no show or missed appointments without prior notice. This fee will be payable upon next appointment.
5. We will forward any accounts past due to our attorney or collection agency.

I understand that even if I have insurance coverage, I am responsible for any unpaid balance on my account. I agree that if Natural Approach is forced to employ any attorney or collection agency, or both, to collect an amount owed by the patient for services rendered, the patient shall pay the amount of any fees incurred.

Name: \_\_\_\_\_

Signature of  
Responsible Party \_\_\_\_\_

Date: \_\_\_\_\_