Office Policies Form

Wolf Creek Acupuncture does **not** provide primary care medicine and is not a substitute for Western medicine. If you think you may have a serious infection, malignant growth, or an injury that won't heal or if you want someone to go over the details of your medical history with you, you need to see a primary care physician (MD and DO).

We can provide complimentary care for conditions, which require a physician's attention. Do **not** expect us to diagnose and treat really serious conditions that need immediate emergency care or require Western medical intervention.

Although we do our best to provide the utmost privacy, there are other people around who may be able to hear private information about you. **Auditory privacy is not guaranteed in either our reception area or our treatment room**. Please be aware of the need for quiet while in the clinic. Turn off your cell phones and electronic equipment prior to entering the clinic treatment area.

We request a 24-hour advanced notice to reschedule or cancel an appointment. In respect to our efforts we request a 24-hour advanced notice to reschedule or cancel an appointment. For any appointments that are rescheduled or canceled within 24 hour advanced notice of the scheduled appointment and for appointments missed without notice, a **$20 fee will be charged.** Fees will be waived for early cancellation for severe weather conditions.

These Policies are subject to change. Any changes made will be posted at our front desk.

We accept the following forms of payment: cash, check, credit and debit cards. **Full payment is due at the time that services are rendered for "time of service discount" charges.** There will be a $20.00 fee charged for all returned checks, plus the face value of the check.

I have read, or have had read to me, the above policies. I have also had an opportunity to ask questions about their content and by signing below I am agreeing to the above-listed policies. I intend for these policies to be in effect during all of my present and future treatments at Wolf Creek Acupuncture.

Patient's name: _____ Signature: _____ Date: _____
(Please print)
Representative's name: _____ Signature: _____ Date: _____
(Please print if applicable)
Relationship to patient: _____