

Acupuncture Now LLC  
Kort G Schmidt L.Ac  
1118 12th St. SE  
Salem, OR.97302  
(503) 952-6781  
[Kort@AcupunctureNow.org](mailto:Kort@AcupunctureNow.org)

## Patient Acknowledgement

Please read and initial the following:

\_\_\_\_\_ I have completed my new patient forms in person or online & I attest that all information I have provided is true and current to my knowledge.

\_\_\_\_\_ I have read or have had read to me the informed consent form. I understand the risks of any & all procedures conducted at Acupuncture Now LLC. I have been given an opportunity to ask any question regarding the treatment procedures and have been provided satisfactory answers for my questions.

\_\_\_\_\_ I have read or have had read to me the arbitration agreement and agree to have any issue of medical practice decided by neutral arbitration & that I am giving up my right to jury or court trial as per section 1 of that agreement.

\_\_\_\_\_ I have read or have had read to me, Acupuncture Now LLC's privacy practices. I have been given an opportunity to ask any questions regarding the protection of my privacy, have been provided with satisfactory answers & agree to the methods Acupuncture Now LLC shall use to protect my privacy.

\_\_\_\_\_ I have read or have had read to me Acupuncture Now LLC's cancellation, re-scheduling & no-show policies & agree to provide at least 24 hours notice in the event I will be unable to arrive to a scheduled appointment.

\_\_\_\_\_ I authorize Acupuncture Now LLC to release my medical records upon request by individuals &/or organizations that I have authorized to view my medical records. Authorization must be presented by a third party prior to release. I further authorize the following individuals to discuss matters related to my treatment at Acupuncture Now LLC

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

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

\_\_\_\_\_ I give permission for Acupuncture Now LLC to contact me by email &/or by phone for matters related to my treatment, including but not limited to, appointment reminders, insurance

coverage & policy change.

\_\_\_\_\_ I give permission for Acupuncture Now LLC to leave messages at the phone number I provided

I understand that payment is due in full at the time of service unless I am using a third party, such as an insurance carrier, to pay for my treatment, or unless otherwise stated and understood by the provider. I have been told the expected costs of my treatment & agree to pay for any services I receive at Acupuncture Now LLC. I understand that in the event a third party does not pay for my treatment services, for any reason, I am responsible for the unpaid balance in a timely manner. I understand that in the event of an unmet deductible I am responsible for paying for the services until the deductible has been met. In the event of an overpayment I understand that Acupuncture Now LLC will credit the difference back to me in a timely manner. I understand that details of any third party that I intend to use for payment is my responsibility to be familiar with; this includes but is not limited to treatments covered, deductibles & or out of pocket limits & benefits coverage. In the event that my third party changes, I understand it is my responsibility to notify Acupuncture Now LLC.

By signing below I agree to the previous statements. I also attest that the following is true; I am at least 18 years of age or have a parent or legal guardian present, I give permission to licensed acupuncturists associated with Acupuncture Now LLC to perform services outlined on the informed consent with me.

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date