

Summer Waters, LAc, NTP, CGP

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You may refuse to sign this acknowledgment****

Name _____ Date _____

Address _____ Phone _____

I, _____, have received a copy of this office's HIPPA privacy notice.

Patient Signature _____

Patient Representative Name _____

Patient Representative Signature _____

* * * * *

FOR OFFICE USE ONLY

We attempted to obtain written Acknowledgement of Receipt of Privacy Practices but acknowledgement could not be obtained because:

- Patient refused to sign
- Communication barriers prevented obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)

PRICING and FINANCIAL POLICY

<i>Service</i>	<i>Fee</i>	<i>Hardship Scale</i>
Comprehensive Consultation for Chronic Conditions – includes initial 2-hour intake and 1-hr follow up consultation	\$350	n/a
Initial New Patient/ Reinstatement Consultation (in-person or at-a-distance)	\$240	n/a
Follow-up Consultation (in person)	\$120	\$90 to \$119

UNDERSTANDING THE HARDSHIP SLIDING FEE SCALE:

Summer recognizes that we are all governed to some extent by our personal economy. Unfortunately for many, one of the first areas to suffer is our healthcare. While cutting healthcare may reduce our budgets a little in the short term, in the long run it is very costly—we commonly develop chronic conditions and acute issues can worsen.

Summer wants you to take care of your health and to help you she developed a sliding fee scale. If you are under financial duress, you may choose to pay any amount between the lower sliding scale price listed on the fee schedule. If you feel you do not need the full hardship discount you may pay anywhere upwards of the base hardship fee. Unlike many medical practices, Summer does not require you provide documentation of your financial hardship. She trusts your integrity and knows you will only use the sliding fee scale if you need it. If a patient abuses the hardship sliding fee scale, Summer reserves the right to discontinue care.

MAKING PAYMENTS:

- ☛ *Payment for services and Wellness Shop items are due at or before time of service (cash, check, credit or debit card)*
- ☛ *Wellness Shop charges are separate from fees for service.*
- ☛ *No returns are allowed on compounded pharmacy items (tincture, creams, etc.), special orders, opened items, or potentially perishable items such as oils that may have been left in a hot car, at the sole discretion of Summer Waters.*
- ☛ *Please make all checks payable to Summer Waters, LLC.*
- ☛ *Visit www.SummerWaters.com/payments to make your payment online with Visa, Mastercard, American Express or Discover.*
- ☛ ***At-a-distance patients need to make their payment at least one day before their scheduled appointment** by visiting the link above and entering the required information. Proof of payment will be automatically received by our office.*



REINSTATEMENT CONSULTATION:

If a patient has not been seen by Summer for a consultation for one calendar year or is not currently enrolled in a SAVOR YOUR HEALTH program, the patient requires a reinstatement consultation. Our health is fluid and many aspects of it can change in a year. This reinstatement is to ensure Summer has the current health information necessary to optimize your treatment.

RETURNED CHECK AND OTHER FEES:

There is a \$35 fee on all returned checks. This is to cover bank fees charged in the event of a returned check.

A \$100.00 deposit is required to book an initial appointment. This nonrefundable deposit holds your scheduled appointment time and will be applied to your initial appointment rate. The initial appointment balance is due at the time of your initial appointment.

A valid credit card is required to be kept on file for any charges to be made for late cancellations, no-show appointments, and other approved charges. By signing below, you understand that it is your responsibility to notify us if your credit card information needs to be updated. Please see the section below for details.

LATE CANCELLATION AND NO-SHOW APPOINTMENT POLICY:

We require 36 business hours notice for cancellation or rescheduling of an appointment. Due to a limited number of available appointment spots for in-person patients, we require any Tuesday appointment cancellations be submitted by 4:00 p.m. Friday of the previous week. This allows us time to rebook for other patients who would like to get in sooner. Thank you for your understanding and cooperation. **All appointments cancelled with less than 36 business hours notice are subject to a \$50.00 fee.** Out of consideration to other patients who would like to receive care, **all missed or "No-Show" appointments will be charged the full rate of the scheduled appointment.**

Call 541-326-8952 for any appointment cancelations or changes. **Do not cancel by email.** For information about cancellations or refunds on programs, please see the program materials.

I have read the above two-page PRICING AND FINANCIAL POLICY and understand, and hereby agree to the fee schedule and policy terms as stated.

Printed Name: _____

Signature

Date

CREDIT CARD AUTHORIZATION FORM for Summer Waters, LLC

A valid credit card is required to be on file to receive care with Summer Waters, LLC.

Summer Waters, LLC, reserves the right to charge for late cancellation fees or missed appointments, as defined above. Please complete all fields in this form. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: <input type="checkbox"/> MasterCard <input type="checkbox"/> VISA <input type="checkbox"/> Discover <input type="checkbox"/> AMEX <input type="checkbox"/> Other
Card #: _____
Cardholder Name (as shown on card): _____
Last 4 digits of Card Number: _____
Expiration Date (mm/yy): _____ CVV (3 Digit Code): _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____
authorize Summer Waters, LLC to charge my credit card, listed above, for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Customer Signature

Date Signed

INFORMED CONSENT for TREATMENT

I, hereby request and consent to the performance of acupuncture treatments and other procedures that are within the scope of practice of acupuncture on me (or for the patient named below, for whom I am legally responsible) by Summer Waters, LAc., NTP, CGP. I understand that methods of treatment may include, but are not limited to, acupuncture, Far Infra-Red (FIR) heat therapy, Cranial Electrotherapy Stimulation (CES), Chinese herbal medicine, nutritional supplements, and lifestyle and nutritional counseling. I understand that I have the right to refuse any or all treatments recommended to me by Summer Waters, LAc, NTP, CGP.

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. 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 Summer Waters, LAc, NTP, CGP, uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of heated lamp therapy. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

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 Summer Waters, LAc, NTP, CGP, of any unanticipated or unpleasant effects associated with the consumption of the herbs. 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. I will notify Summer Waters, LAc, NTP, CGP, if I am pregnant, become pregnant, or am trying to become pregnant. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

I agree to keep Summer Waters, LAc, NTP, CGP, informed of any changes in my medical condition. I do not expect Summer Waters, LAc, NTP, CGP, to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on Summer Waters, LAc, NTP, CGP, to exercise judgment during the course of treatment she thinks at the time, based upon the facts then known, is in my best interest. I acknowledge that my condition and the potential benefits of acupuncture have been discussed with me. I have had the likelihood of success explained to me, and I understand that results are not guaranteed, and that my participation in my own treatment and quantity of treatments may significantly influence the outcome and results.

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 also acknowledge that other treatment options have been presented to me. 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 or Patient Representative –
including relationship if signing for patient

Date

BINDING ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to 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 Oregon law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute 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 the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the health care practitioner, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care practitioner, and the practitioner's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for the loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the health care practitioner to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

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 parties within thirty days of a demand for a neutral arbitrator by either party. 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 counseling fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nor supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties' consent to the intervention and joinder in this arbitration of any person or entity, which 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.

Article 4: General Provisions: 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 Oregon statute of limitations, or (2) the claimant fails to pursue the

BINDING ARBITRATION AGREEMENT Continued (pg. 2/2)

arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the Oregon Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the health care practitioner within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

_____ Effective as of the date of first medical 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.

Patient Name Print

Patient Signature or Patient Representative –
including relationship if signing for patient

Date

Practitioner Name Print

Practitioner Signature

Date