COLORADO MANDATORY DISCLOSURE STATEMENT

THE POINT
1705 South Pearl Street #4
Denver, CO 80210
720.523.3351

Please read the following and sign below after you have had any questions answered and have understood this statement to your satisfaction.

Fee Schedule
Payment is due at the time of service. If your insurance does not cover this service, there is a time of service discount applied. The current discounted rates are:

Acupuncture	
Initial Visit	$95 + cost of herbs
Follow-up Visit	$75 + cost of herbs
Facial Acupuncture	$125
Craniosacral and Neuro-behavioral Health & Life Coaching	
Initial Visit	$175
Follow-up visits	$115

Any services offered by an employee at The Point Acupuncture & Holistic Medicine, LLC are not intended to substitute for those offered by a licensed medical doctor when needed. Referrals are made for further workup and treatment when appropriate. Patients may seek a second opinion from other health care practitioners or terminate therapy at any time. The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy.

This clinic complies with the rules and regulations promulgated by the Colorado Department of Health, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are utilized. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Acupuncturists Registration Office, 1560 Broadway, Suite 1350, Denver, Colorado 80202; (303) 894-7800.

I have read and understand this document, have had an opportunity to have any and all questions answered on the subject, and freely seek the services offered.

_____ _____
Patient's or Guardian's Signature *Date*

OFFICE POLICIES

Cancellations & missed appointments. Please provide 24-hour notice of cancellation prior to your scheduled appointment. If you miss an appointment or cancel within 24 hours you will be charged a $50.

Reasons for being dismissed/denied treatment: Patients who show inappropriate conduct, non-or-late payment of fees, or safety concerns may be denied treatment.

FINANCIAL POLICY

Your payment is due in full at the time of service. For your convenience, we accept cash, check or credit cards (Visa or MasterCard only). For checks returned to us as unpaid by your bank, you will be charged a $25 fee.

INSURANCE POLICY

Many Insurance companies cover acupuncture! We are happy to verify coverage and check benefits for you. If you have insurance that covers acupuncture we will submit your claims for you. You are responsible for your deductible, co-payment, and any non-covered or excluded amounts under your policy. If your insurance denies payment of a claim *you are responsible for billed charges*. In the case that your insurance company sends a check directly to you for the payment of the treatment, you hereby agree to endorse the check to THE POINT and turn over payment with accompanying Explanation of Benefits form.

Procedure Code	Description of Service	Billed Charge	Time of Service Discount
99203	New Patient Evaluation	$95	$95
97810	Acupuncture, first 15 minutes	$70	$75
97811	Acupuncture, additional time	$50	0
97014	Electric Stimulation	$10	0
97016	Cupping Therapy	$20	0

RECORDS RELEASE & ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information to claims for benefits submitted. I further agree and authorize Katherine Altneu L.Ac. to submit claims for benefits, for services rendered, without obtaining my signature on each claim. I understand that I am financially responsible for all charges incurred, whether or not they are covered by my insurance company. This authorization shall remain valid until written notice is given by me revoking said authorization.

Please indicate your understanding and acceptance of these policies by signing below.

_____ _____ _____

Patient's Signature *Patient's Name* *Date*

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Consent to Treatment

By signing below, I do hereby authorize Licensed Acupuncturists at THE POINT to administer any style of Oriental Medicine relevant to my diagnosis and treatment, including but not limited to the following:

Acupuncture: I understand that acupuncture is performed by the insertion of needles through the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Moxibustion: I understand that heat treatments using Artemesia vulgaris ("moxa") involves putting moxa on the head of a needle while inserted in the skin, or directly on the skin. The heat generated from moxa treatments may involve a slight discomfort or leave a blister or scar on the skin. I understand that I may refuse this therapy.

Chinese Herbs: I understand that Chinese Herbal formulas may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, or abdominal pain or discomfort. *Should I experience any problems which I associate with these substances, I should suspend taking them and call THE POINT as soon as possible.*

Cupping: I understand that cupping may be used to promote circulation of qi though the meridians. Cups may produce a red/purple color on the area treated lasting for 1 – 5 days.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

Most conditions require an average of 6-12 treatments, although some will respond within 4-6 treatments and others may require a longer series – this depends the severity and the chronic nature of the chief complaint.

I have been informed that I have the right to refuse any form of treatment. I understand the nature of the treatment, have been informed of the risks and possible consequences involved in the treatment, and have been given an opportunity to ask questions pertaining to the treatment. I also understand that there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I understand that acupuncturists practicing in the state of Colorado are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ **Date:** _____

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Acknowledgment of Notice of Privacy Practices and Consent to Treat

With my consent, THE POINT may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to THE POINT's **Notice of Privacy Practices** for more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

With my consent, THE POINT may call my home or any other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, THE POINT may mail to my home or other designated location any items that assist the practice carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked as personal and confidential.

With my consent, THE POINT may email me appointment reminders and patient's statements. I have the right to request that THE POINT restrict how it uses or discloses my PHI to carry out TPO.

By signing this form, I am consenting to THE POINT's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, THE POINT may decline to provide treatment to me.

I, _____, hereby acknowledge that I read and reviewed a copy of THE POINT's Notice of Privacy Practices and fully understand this consent form. I am consenting to the use and/or disclosure of my health information to treat me and arrange for my medical care. I am consenting to be treated.

_____ _____

Signature of Patient or Parent/Legal Guardian *Date*

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