LEVIN 道 THERAPEUTICS

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Patient's Rights, Acupuncture Informed Consent, Refund and Cancellation Policies

Patient Rights Notice

Each patient who visits this office is entitled to receive information about the methods of therapy, the techniques used, and an estimated duration of therapy, if known. The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Pennsylvania State Board of Medicine, P.O. Box 2649, Harrisburg, PA 17105-2649. Phone - (717) 783-1400 Fax - (717) 787-7769 *ST-MEDICINE@PA.GOV*

I have read and understand the above disclosure statement. I understand my rights and responsibilities as a patient. _____ (initial here)

Acupuncture Informed Consent Notice

Acupuncture has been explained to me as a treatment consisting of the insertion of needles through the skin at specific points on the surface of the body (small amounts of electrical current may be applied to the needles). The purpose of acupuncture has been explained as the alleviation or cure of symptoms or disorders.

Acupuncture, acupressure, Moxa, cupping therapy, allergy elimination technique, nutritional or herbal counseling are considered experimental procedures and are not considered a substitute for Western Medicine. Therapies and advice offered shall not be construed by the client to be a diagnosis of treatment of any disease or injury. We recommend that you CONSULT YOUR PHYSICIAN for any serious conditions and receive at least two medical opinions. It is your right and responsibility for your own body.

I understand that complications may result from acupuncture treatment. Among these possible complications are: areas of anesthesia, fainting, weakness, nausea, hematoma, infection, pain and discomfort, pneumothorax, and aggravation of present symptoms. Being hungry, tired, or stressed can infrequently make the body more sensitive to the acupuncture treatment. Please tell your provider if you have any conditions that may inhibit blood clotting, such as hemophilia or Coumadin use. Please use caution when walking with bare feet in the treatment room.

I further understand and agree to hold harmless, to indemnify and to protect against court action the individual therapist as well as the management and owners of this clinic, in the event of accidental injury on these premises. _____ (initial here)

Patient Cancellation, No Shows, Late Arrivals and Refund Policies

Levin Therapeutics understands that unanticipated events can happen in everyone's life. However, in order to best serve all patients, and for patients to be fair to each other the following policies are effective once an appointment is scheduled.

24-Hour Notice for Cancellations

If a patient needs to cancel or reschedule for any reason, at least 24 hours' notice is required. This allows the opportunity for another patient to schedule an appointment. If 24 hours' notice is not provided than full payment is required. If the practitioner needs to cancel the appointment for any given reason, they will make all efforts to do so with at least 24 hours advance notice.

No-shows

Patients who either forget or consciously choose to forgo their appointment for whatever reason will be considered a "no-show." No-show appointments are *non-refundable*.

Late Arrivals

If a patient arrives late, the session may be shortened in order to accommodate following appointments. Depending upon how late the patient arrives, the practitioner will determine if enough time remains to start a treatment. Regardless of length of treatment given, the patient is responsible for a "full" session. We ask that out of respect and consideration to your practitioner and all other patients please plan accordingly to be on time.

Refund Policy

All purchases are non-refundable. If you have made a purchase in error, prompt communication with Levin Therapeutics is required.

I have read and understand the above Patient Cancellation, No Shows, Late Arrivals and Refund Policies statement. I agree to the conditions set forth in this statement. _____ (initial here)

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS. I AGREE TO THE CONDITIONS SET FORTH IN THESE STATEMENTS.

PATIENT NAME (PLEASE PRINT): _____

SIGNED: _____ DATE: _____

SIGNATURE (PATIENT, OR PARENT/LEGAL GUARDIAN OF PATIENT)