sahm ACUPUNCTURE HEAVEN | EARTH | HUMANITY
594 Broadway, Suite 905 New York, NY 10012 (646) 279-8836

Office Policies

Cancellation Policy

At Sah'm acupuncture, we are committed to providing you the highest quality of care.
Please be respectful of the time set aside for your treatment.
Therefore, all scheduled appointments require a **24 hour cancellation notice** or the patient will be held financially responsible.

Each late cancellation will be billed at a rate of $85 per visit each.
NO SHOW or **CANCELLATION ON DAY OF APPOINTMENT** will be billed for a **FULL** office visit fee. _____ intial here.

This agreement applies to missed appointments due to patient illness, weather conditions, transportation issues, family emergencies (some exceptions apply) or personal/professional commitments.*
Please understand that missing an appointment for any of the aforementioned reasons denies another patient a valuable and necessary service. Therefore we find it necessary to implement and enforce this policy.

Signing your name below assures Sah'm acupuncture that you have read and understood this agreement.

PRINT NAME:_____ Date:_____

SIGNATURE: _____ Date:_____

NAME ON CARD:_____

CARD # _____ Exp Date: ___/___ AMEX VISA MC OTHER:_____

*Please call or text message us, if you are running late and we will accommodate you up 15mins. After 25 mins, Sah'm Acupuncture reserves the right to **CANCEL** the existing appointment and the patient will be charged for a **FULL** office visit fee.*

ARTICLE 160, section 8211.1(b) of NYS Education Law

Each Acupuncturist licensed pursuant to this article, shall advise each patient as to the importance of consulting with a licensed physician regarding the patient's condition and shall keep on file with the patient's records, a form attesting to the patient's notice of such advice. Such form shall be in duplicate, one copy to be retained by patient, signed and dated by both the Acupuncturist and the patient, and shall be prescribed in the following manner.

We, the undersigned, do affirm that (the patient) has been advised by (a licensed acupuncturist), to consult a physician regarding the condition or conditions for which a patient seeks Acupuncture treatment.

Authorization to Release Medical Information

I hereby Authorize J. Leah Kim, MSTOM, Dipl. Ac., L.Ac., to release any and all records, medical history, services rendered or treatment given to me for purpose of review, investigation or evaluation of claim submitted to my insurer(s).

Assignment of Benefits for Insurance

I authorize payment of benefits be made directly to this healthcare provider and I understand I am responsible for charges not covered by this assignment. I also authorize the release of any information requested to process this claim.

Returned check policy

All returned checks will be subject to an additional charge of $35.00

By signing this agreement, I am acknowledging that I have read the above financial policies and will be responsible for all charges stated above.

Print Patient Name	Patient's signature	Date
Print Acupuncturist's Name	Acupuncturist's Signature	Date