

ART OF WELLNESS PATIENT INFORMATION SHEET

Art of Wellness ©2023

 First Name Last Name Middle Initial Sex Age Birth date

 Social Security # Driver's License # Marital Status Cell phone Home Phone

 Home Address Unit # City State Zip Code

 Email Employer Name Occupation

 Emergency Contact Name Relationship Phone # Address

 Physician Name Specialty Phone # Address

 Insurance Carrier Member # Name of Insured Relationship to Insured

Referred By: _____
 Address Phone #

Office Policies

1. Art of Wellness is required by law to maintain the privacy and confidentiality of your protected health and personal information. This policy is available in our waiting room for you to read or you can request a written copy. Please ask the receptionist for more information.
2. If you need to cancel your appointment, please inform us at least 24 hours prior to your appointment. **A missed appointment will be charged at full rate.** (see fee schedule below)
3. There is a service fee of \$35.00 for every returned check from the bank
4. **We are out of network providers.** Please contact your insurance company to verify out-of-network acupuncture benefits. We will provide you with a superbill form that may be sent to your insurance company for reimbursement.
5. You authorize the release of your medical records or any information necessary to process a claim with your insurance company in case they contact us.
6. We accept payment as: Personal Checks, Cash, Visa, Mastercard, Discover and American Express.
7. Herb pick up orders require a credit card authorization at the time of order, you will be charged in full once herbs have been prepared. There are no returns on any opened powder or raw herbs. Unopened herbs may be returned for credit only.

FEE SCHEDULE as of 2023

Doctor	Consultation	Acupuncture	Cupping	F/u Consultation	Herbs (wkly)	Missed Appointment.
Dr. Qineng Tan	\$150	\$145	\$40	\$130	\$50 and up	\$145
Dr. Xiaomei Cai	\$150	\$145	\$40	\$130	\$50 and up	\$145

X _____
 Signature of Patient

X _____
 Signature of Parent/ Guardian
 (If patient is a under 18 yrs old)

X _____
 Date