Tracy Andrews
ACUPUNCTURE

CONFIDENTIAL PERSONAL INFORMATION

Full Name:_____/_____/_____
(Last Name) (First Name) (Middle Initial)
Preferred Name: _____ Age: _____ Date of Birth: _____

Address:_____/_____/____/_____
(street#/PO Box) (city) (state) (Zip code)
Telephone#(____)_____/_(____)_____/_(____)_____
(home) (work) (cell phone or other)
E-mail address: _____

Occupation: _____(circle) full-time/part-time/student/retired/unemployed
Employer: _____
Sex assigned at birth: female male intersex
Gender identity (circle one) female male transgender nonbinary Preferred pronouns? _____
Any cultural identities you'd like us to know about? _____
Are you (check one): Single ____ Partnered ____ Married ____Widowed/widower ____
Partner's Name: _____

You do not need to enter insurance information if you are not using insurance benefits.
Insurance company _____
Insured's Name _____ Insured's DOB _____
Insurance ID No.: _____ Group No. _____ Plan year dates _____
Acupuncture Benefits: _____ (visits or total amount) Deductible amount: _____ Deductible met? Y or N
Physical/Manual Therapy Benefit: _____(visits or total amount) Deductible amount: ____ Deductible met? Y or N
Co-pay or Coinsurance _____
Have you confirmed that your practitioner is covered by your insurance? Y or N

Have you had a motor vehicle or work-related accident claim in the last two years? (circle) Y N
Is the reason for your visit due to a motor vehicle or work-related accident? (circle) Y N
Claim # (MVA or Worker's Comp) _____
Adjustor: _____ Phone: _____

Emergency Contact _____ /_____
(Name) (Relationship)
(_____)_____ (_____)_____
(Day Phone) (Evening Phone)

What is the best way to communicate with you between office visits? (circle one) E-mail, Home, Work, Cell Phone Is there any place you do NOT want me to leave a message? _____

By signing below, I verify that the above information is correct and true to the best of my knowledge.
Signature of Patient _____Today's Date_____

200 NE 20th Ave • Ste 120 • Portland OR 97232
tracy@tracyandrewsacupuncture.com
Ph. 971-251-0320 • F. 503-893-3103

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INFORMED CONSENT FOR TREATMENT

Please read and initial each statement, indicating that you have read, understood, and agree. Please ask if you have questions. This form must be signed before we can begin treatment. If you prefer to have your practitioner read through this form with you and explain each section, please ask!

I request and consent to treatment for myself (or the below-named patient for whom I am legally responsible) with procedures and techniques including but not limited to: acupuncture, Chinese or western herbal therapy or supplements, moxibustion, cupping, somatic resilience and regulation touch therapy, gua sha (scraping), craniosacral therapy, manual therapy, lifestyle/nutritional guidance, somatic parts or Internal Family Systems parts work (Tracy's patients only), Focusing, instruction in qigong, somatic, breathwork, and/or rehab/conditioning movements/exercises. ____

I understand that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Unusual risks, which the practitioner takes careful precautions to avoid, include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is a possible risk, although the practitioner below uses sterile disposable needles and maintains a clean and safe environment. I understand that I should not make significant movements while the needles are being inserted, retained, or removed. ____

I understand that NeuroAffective Touch, somatic resilience and regulation touch therapy may help to address physiological and somatic expressions of trauma; I understand these are not a substitute for mental health therapy or psychiatry and that they should be used in conjunction with psychiatric or mental health services. I understand that my practitioner is not a mental health therapist, counselor, or psychologist and that I may request care coordination between my practitioner and my mental health, psychiatric and/or primary care providers. I understand that I may be asked to sign a release authorizing my practitioner to speak with my other providers ____

I understand that certain interventions may be contraindicated for hemorrhage, stroke, blood clots, tumors, recent surgeries, or traumatic injuries. I am not currently experiencing any of these conditions to the best of my knowledge or I have notified my practitioner of these conditions. ____

Side-effects of cupping, bleeding and gua sha may be bruising or temporary skin discoloration. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I understand that I may opt out of these treatments at any time. ____

The herbs and nutritional supplements (which are from plant, mineral, and animal sources) that may be

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recommended are traditionally considered safe in the practice of Chinese medicine but may be toxic in large doses or when taken incorrectly. I understand that many herbs are inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that the herbs need to be consumed according to the instructions provided orally and/or in writing and I will immediately notify my practitioner if my symptoms change or if I develop any effects associated with the consumption of the herbs or other supplements. I will keep my practitioner informed of my medications and other supplements to reduce the risk of herb-drug interactions. ____

I have stated all my known medical conditions and take it upon myself to keep my practitioner updated on my physical health. I will notify my provider if I am or become pregnant or I have a bleeding disorder. I will notify my practitioner of any significant changes in my health or new diagnoses by my primary medical physician. I understand that my practitioner encourages me to see a primary medical physician and mental health therapist on a regular basis. I release the practitioner from responsibility and liability for any adverse reactions resulting from disclosed and undisclosed conditions. ____

I do not expect my practitioner to anticipate and explain all possible risks and complications of treatment, and I wish to rely on my practitioner to exercise judgment during the course of treatment. I understand that results are not guaranteed. ____

By voluntarily signing below I show that I have read, or have had read to me, this 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 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.

I would like to OPT OUT of the following interventions: _____

I have questions about the following interventions or risks_____
_____

I have had the opportunity to read this form and my questions are answered to my satisfaction. I hereby consent to the treatments initialed above.

Printed Name:_____
Printed Name of Patient Representative:_____
Signature of patient or patient representative:_____Date:_____

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

This office's full notice of privacy practices related to can be obtained online at tracyandrewsacupuncture.com.

By signing below, I acknowledge that I understand how to access these privacy policies and that I have been given the opportunity to review this office's notice of privacy practices.

Printed Name:_____
Printed Name of Patient Representative:_____
Signature of patient or patient representative:_____Date:_____

PERMISSION TO RELEASE INFORMATION

By initialing here ____ I give permission for my practitioner to acknowledge that I am a patient and to communicate about my healthcare to the following individuals (spouse, partner, family member):

_____

_____

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OFFICE POLICIES

It is our honor to serve you on your journey. Our intention is to sustain practice while providing excellent and personalized care for each of our patients. Your wellbeing is the reason that we do this work. We endeavor to be transparent about all our office policies and practices. Please thoroughly read this document, ask for clarification if needed, and initial each page to indicate that you understand and agree to our financial and billing policies.

We ask that you familiarize yourself with our office policies so that you understand how we handle payment, cancellations, illness, inclement weather, and so on. This document addresses how we handle the following:

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Date:_____

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PAYMENT FOR SERVICES

Full payment is due at the time of service. Cancellation and missed appointment fees are based upon the time-of-service (TOS) rates, listed below:

TIME OF SERVICE RATES

60-minute appointments: $155 ($130 Resident)
75-minute appointments: $190 ($155 Resident)
90-minute appointments: $210 ($180 Resident)

INSURANCE BILLING

You are responsible for paying your coinsurance and/or copayment at the time of your appointment, as well as for any deductible payments (which will likely be invoiced). As a small practice with no administrative support, we do not have the capability to verify insurance benefits - you are responsible for knowing your benefits before your first appointment. We recommend calling your insurance company and verifying that your appointment will be covered for your specific provider. Billed rates are approximately 7% higher than time-of-service/prompt pay rates. You are responsible for services denied or not covered by your insurance, at the billed rate (see fee schedule at the end of this document).

When you speak to your insurance company, please find out the following:

Deductible:
Coinsurance:
Copayment amount:
Number of visits or dollar amount of acupuncture benefit:
Preauthorization required: Yes or No
Acupuncture benefits apply to your specific provider: yes or no

INVOICING & PAST-DUE BALANCES

If you have a balance due on your account after insurance payment has been received, you will receive an invoice from Full Moon Billing, which you may pay by check, card, cash or bank transfer. If you have any difficulties paying your bill, please contact us right away to arrange a payment plan. If we do not hear from you after three billing cycles and we are unable to reach you by phone to discuss payment, your past-due account will be turned over to collections.

PAYMENT METHODS

Check or cash is the preferred form of payment, but you may use credit cards, including Discover and American Express, and FSA/HAS debit cards. You may also choose to use Ivy Pay (see below).

Ivy Pay: Ivy Pay is a HIPAA-compliant payment processing service that will charge your credit, debit or FSA card for your appointment without the need to present your

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card. You will receive a text from IvyPay to enter your name and payment information. After an appointment, you will be charged for the appointment and will receive a text with payment receipt.

Returned Checks: There is a $40 service charge for returned checks.

Superbills/Receipts: Superbills/receipts available upon request.

TREATMENT PACKAGES

Treatment packages offer a discount on pre-paid services and should be used within six months. Packages may be purchased with a check, through an ACH bank transfer (1% service charge) or by credit card (3% service charge). See other restrictions below.*

Five hours of session time:
Tracy $713 ($142.60/hour with 8% prepaid discount)
Resident $598 ($119.60/hour with 8% prepaid discount)
Six hours of session time:
Tracy $837 ($139.50/hour with 10% prepaid discount)
Resident $702 ($117/hour with 10% prepaid discount)
Five 75-minute sessions (6.25 hours):
Tracy $855 ($171 per 75-minute session with 10% prepaid discount)
Resident $697.50 ($139.50 per 75-minute session with 10% prepaid discount)
Six 75-minute sessions (7.5 hours):
Tracy $1026 ($171 per 75-minute session with 10% prepaid discount)
Resident $972 ($162 per 75-minute session with 10% prepaid discount)

RESCHEDULING OR CANCELLING YOUR APPOINTMENT

Missed appointments greatly impact the sustainability of our practice. Please give as much advanced notice as possible if you cannot make a scheduled appointment. As a reminder, we require 48 hours' notice to change or cancel appointments.

Please save your initial confirmation email, which has a link where you can reschedule or cancel up to 48 hours before your appointment. If you have a regular weekly or every-other-week appointment, please notify us as early as possible when you have upcoming travel or other conflicts, as it may be difficult to fill these time slots. If there are multiple cancellations of a regular weekly or every-other-week appointment, we will be unable to reserve that time slot for you in the future.

LATE CANCELLATIONS & “NO SHOW” FEES

Cancellations with less than 24 hours’ notice (including “no show” appointments) will be charged the full time-of-service fee, which cannot be billed to insurance.

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Date:_____

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Cancellations with 24-48 hours' notice will be charged 50% of the TOS appointment fee.

The credit card information or other payment information you previously provided (such as the pre-paid package you used to book the session) will be used to process or credit this payment. By providing your credit card information through the scheduling process and/or IvyPay, you consent to this policy. If you do not have a saved payment method, you will be invoiced for this fee.

Multiple no-shows may result in the termination of services at the conclusion of a pre-paid treatment package.

HOW 48 HOURS NOTICE WORKS

Please notify us two full days (48 hours) before your scheduled appointment time. For example, if an appointment is scheduled for 3:00 pm on a Thursday, notice must be given by 3:00 pm on Tuesday at the absolute latest, but more advanced notice is greatly appreciated.

REMINDERS

As a courtesy, you are automatically sent reminder emails 72 and 48 hours before your scheduled appointment, as well as a text reminder 24 hours beforehand. Please contact your practitioner right away if you do not receive an expected reminder. You are responsible for scheduled appointments, whether or not you receive these reminders.

ONLINE SESSIONS

Your appointment may be conducted online when you are unable to get to the office due to illness, emergency, inclement weather, or travel. Online sessions are appropriate for nearly all treatment plans and may include NeuroAffective Touch, guided somatic visualizations for somatic regulation, herbal medicine prescribing, qigong, self-guided acupressure. Please be sure that you can be in a safe, private, and comfortable location for the duration of your online session. Time of service rates (above) apply in most cases.***

LATE ARRIVALS

Please notify your provider if you expect to be late. We will attempt to reach you by text or phone if you have not arrived 10 minutes after your scheduled appointment time. Arriving more than 15 minutes late for an appointment will be considered a "no show"; it is at the discretion of your clinician whether they will still be able to meet with you with a 15+ minute late arrival. In most cases we can conduct your session online if you contact us to make arrangements within the first 15 minutes of your appointment.

IN CASE OF ILLNESS, EMERGENCY, AND INCLEMENT WEATHER

With the high rate of cancellations in recent years for Covid-19 or Covid-19-like cold and flu symptoms, we are no longer able to waive late cancellation fees for sudden illness and

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emergencies. We will plan to conduct your session online unless you are too ill. So that we can sustain our practices and continue to offer a high quality of consistent care while making allowances for such unexpected events, 50% of the time-of-service appointment fee will be charged for late cancellations related to sudden illness and true emergencies. Except in cases of truly last-minute emergencies, less than two hours' notice for illness or emergency will still be considered a "no show."

ILLNESS

If you are feeling sick, please assess your ability to get to the office or do an online session and use the following guidelines:

If you are feeling well enough to continue daily activities, plan to wear a quality mask to your appointment and let us know you've had symptoms so that we can be sure to thoroughly disinfect surfaces after your appointment.

If you are feeling sick enough that you need to stay home but well enough to engage in conversation, notify your practitioner that you need to do the session online. Your confirmation and reminder emails will have a link for the session.

If you are feeling so ill that you need to stay in bed, please let us know as early as possible so we can cancel your appointment. A cancellation for illness with less than two hours' notice is considered a "no show" and will be charged the full, time-of-service fee.

EMERGENCIES

If you have an emergency, such as a car accident or critical health emergency that requires you to miss a scheduled appointment, please give as much notice as possible. Work situations and scheduling conflicts do not constitute emergencies.

INCLEMENT WEATHER

In the event of inclement weather, we will communicate with you by text or phone call if your practitioner is unable to safely make it to the office. If you do not feel confident that you can travel safely to and from the office, please contact your practitioner and we will send you a Google Meet or Zoom link to conduct your session.

EXTENDING YOUR APPOINTMENT

While 60-minutes is the most common treatment session, 75- and 90-minute sessions are an option that often allow for deeper work, especially when combining acupuncture with somatic and/or manual therapies.

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If, during a treatment, we believe that extending your session beyond the scheduled length of your appointment could be beneficial (and we have the time available to do so), we will inform you that we are approaching the end of our time and ask you if you'd like to extend your session. If you wish to do so, you accept financial responsibility for the additional time in the treatment room as follows:

First 15 minutes: $35 ($25 for Resident)
Second 15 minutes: $35 ($20 for Resident, $20 for Tracy's patients if combined with add-on services)

Patients with insurance coverage may elect to schedule a 75- or 90-minute treatment session and use acupuncture benefits for the regular 60-minute appointment, paying out-of-pocket for the additional time. This is in addition to any non-covered services. See examples in the Non-Covered Services addendum below.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have fully read and understand these office policies and practices and that I may access them at any time from tracyandrewsacupuncture.com. I agree to the terms and acknowledge that I am financially responsible for services I receive.

Patient Name: _____
Patient Signature _____
Date: _____

CLARIFICATIONS

* After six months any unused sessions are converted to the remaining cash value of the treatment package and may be applied to future sessions or refunded. Unused portions of treatment packages may be refunded upon request as follows: (Total paid) - (number of sessions used at the non-discounted rate) = refunded amount.

**Somatic regulation (including NeuroAffective Touch and Somatic Resilience & Regulation touch work) and craniosacral therapies are hands-on modalities that we may recommend as part of your care. Both therapies can have beneficial effects for stress and nervous system responses, with somatic regulation therapy having a specific focus on addressing symptoms related to the physiology of developmental stress and trauma (adverse experiences in utero, birth, or early childhood, including attachment issues). Please let us know if you are unclear about these therapies and whether they should be part of your care.

*** In some cases, we may be able to bill insurance to cover 15-30 minutes of your online session. You will need to fill out the "updated health concerns" form and plan to pay your copay or coinsurance as well as time-of-service fees for the rest of your appointment time.

ADDENDUM A:

Initials:_____
Date:_____

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RECEIVING NON-COVERED SERVICES (INSURANCE ONLY)

Insurance coverage for a follow-up appointment typically pays for 45 minutes of treatment with acupuncture (with 1 or more needles inserted each 15 minutes), as well as periodic office visits for evaluation and management of your case.

In this practice, you are asked to take a more active role in your care by making informed choices about electing to receive non-covered services as out-of-pocket expenses. Services that acupuncture benefits generally do not cover include craniosacral therapy, somatic regulation therapy (including NeuroAffective Touch), somatic parts & Internal Family Systems parts work, cupping, and other manual therapies.** If your insurance benefits cover manual therapy, we can discuss whether it is appropriate to bill insurance, as these benefits apply only to certain conditions and there may also be an additional copay or coinsurance as well as required preauthorization.

There is an add-on fee for non-covered services received in session. This is only applied once per session, regardless of session length (it is not a time-based fee). The out-of-pocket fee for non-covered services is $45 (Tracy) or $30 (Resident) per session, in addition to your usual copay/coinsurance.

Example: You have a $15 copay and elect to receive somatic regulation and craniosacral therapy.

With Tracy, your financial responsibility is for $60
($15 copay + $45 for non-covered services)
With Resident, your financial responsibility is for $45
($15 copay + $30 for non-covered services)

Example: You have a $30 coinsurance and wish to schedule an extra 15 minutes onto your acupuncture appointment.

With Tracy, your financial responsibility is $65
($30 coinsurance + $35 for additional 15 minutes)
With Resident, your financial responsibility is $55
($30 coinsurance + $25 for additional 15 minutes)

Example: You have a $15 copay and elect to receive craniosacral therapy with your acupuncture and to extend your appointment to 75 minutes.

With Tracy: your responsibility is $95
($15 copay + $45 non-covered services + $35/additional 15 minutes).
With Resident: your responsibility is $70
($15 copay + $30 non-covered services + $25/additional 15 minutes).

Example: You have a $20 copay and schedule 90 minutes to receive somatic regulation along with acupuncture.

With Tracy: your financial responsibility is $120
($20 copay + $45 non-covered services + $35 for the 1st 15 minutes + $20 for the 2nd 15 minutes).

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With Resident: your financial responsibility is $95
($20 copay + $30 non-covered services + $25 for the 1st 15 minutes
+ $20 for the 2nd 15 minutes).

If we believe that a non-covered therapeutic service is strongly indicated, we will talk with you about the options and give you the opportunity to add on these services within your session and ask you to sign a consent form to receive non-covered services (if you have not already). Together we can discuss what services will best support your health and wellbeing to help you make these choices.

Tracy's patients only: My practice focus is providing quality trauma-informed, somatic touch therapy along with acupuncture and I therefore have limited availability for acupuncture-only appointments. If either of us feel that you would benefit from more focused acupuncture care, I may recommend an acupuncturist who can better meet your needs.

CONSENT TO RECEIVE NON-COVERED SERVICES

I have been informed and I understand that certain treatments are considered non-covered services. I hereby consent to receive these non-covered services and accept full responsibility for payment of these services.

I understand that I may verbally notify Tracy Andrews, LAc, that I do not wish to receive non-covered services during an individual treatment session without revoking this "Consent to Receive Non-Covered Services." I understand that I may revoke this "Consent to Receive Non-Covered Services" through written notice to Tracy Andrews, LAc, at any point.

Please initial next to services you consent to receive with full financial responsibility:

____ Treatment for a non-billable condition
____ NeuroAffective Touch and/or Somatic Regulation Touch Therapy
____ Somatic parts and/or Internal Family Systems parts work
____ Additional treatment denied by insurance authorization process
____ Manual therapy (cupping or craniosacral therapy) as a private payer, not billed to insurance

Patient Name: _____
Patient Signature _____
Date: _____

Initials:_____
Date:_____

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ADDENDUM B BILLING FEE SCHEDULE

CPT	Description	Fee/unit (Tracy)	Fee/unit (Resident)
97810	Acupuncture, initial 15 min	63	55
97811	Acupuncture, additional with re-insertion, additional 15 min.	52	46
97813	Electro-acupuncture, initial 15 min.	75	65
97814	Electro-acupuncture, additional with re-insertion, additional 15 min.	65	55
99201	Focused intake	95	59
99202	Expanded intake	188	95
99203	Detailed intake	206	148
99211	Focused exam, returning patient	50	35
99212	Expanded exam, returning patient	65	65
99213	Detailed exam, returning patient	85	85
97110	Therapeutic exercise to develop strength, endurance, ROM, 15 min.	51	45
97124	Therapeutic procedure, massage, 15 min.	56	56
97140	Manual therapy – mobilization, manipulation, manual lymphatic drainage, manual traction, 1 or more regions, 15 min.	56	56
97799	Non-covered and unlisted therapeutic services	50	44
X	Elective cupping	43.75	

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