
## Notice of Payment Policy

I understand that I should be evaluated by a physician for the condition I am requesting consultation. The treatment I am being given at Stillpoint Acupuncture & Healing Arts does not constitute a western medicine diagnosis.

Stillpoint Acupuncture & Healing Arts has informed me that it does not participate with my insurance, and accordingly I understand and assume financial responsibility for all charges pertaining to all items and services received. Furthermore, I understand that payment is due at the time of service.

To best serve you, appointment slots are not double-booked. The office reserves the appointment time for only your visit. I understand that there is a 48 hour cancellation policy. I understand that I will be charged the full cost of the treatment if I have a missed appointment or a late cancellation.

**Acceptance of Payment Policy**

My signature below indicates that I have read, understood and accepted Stillpoint Acupuncture & Healing Arts Payment Polity.

Patient Name: _____

Patient Signature: _____Date: _____
(Or Patient Representative – Indicate Relationship to Patient)

Stillpoint Acupuncture & Healing Arts
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