Alpine Acupuncture, LLC
628 NW York Drive, Suite 104
Bend, Oregon 97703
(541) 330-8283

Steven A. Foster-Wexler, LAc
Licensed Acupuncturist, Certified Qigong Instructor
State License #AC00762
Tax ID# 20-0452417

OFFICE PROCEDURES

Name: _____SS#:_____-____-_____
Home Address: _____ City _____ State_____ Zip: _____
Home Phone: _____ DOB: _____ Age: _____ Sex _____
Cell Phone: _____ Email: _____
Marital Status: ___Single ___Married ___Divorced ____Partner ___Widow(er)
Employer: _____ Occupation: _____
Work Address: _____ Phone: _____
Emergency Contact: _____Relation: _____ Phone: _____
Referred by: _____ Relation: _____

I understand that acupuncturists practicing in the state of Oregon are not primary care providers and that regular primary care by a licensed physician is an important choice that is recommended by Alpine Acupuncture, LLC. I understand that Alpine Acupuncture, LLC requests that all patients have a primary care provider as part of a comprehensive care program and that all patients provide medical records from this provider upon request.

APPOINTMENT CHANGES:

We require a minimum of 24 hours advance notice in order to reschedule an appointment. We reserve the right to charge for patients who neglect to reschedule 24 hours in advance.

PAYMENT OF SERVICES:

Payment is due at the time of service unless arrangements are made in advance. We accept Visa, MasterCard, American Express, personal check, or cash.

We have found this policy to be most effective for both patients and providers. If you foresee any financial challenges, be sure to address them with us prior to your appointment.

I have read, understand, and agree to the above statement regarding responsibility for my health care and payment policy.

(Date)

PATIENT SIGNATRE **X**
(Or Patient Representative) (Indicate relationship if signing for patient)

INSURANCE RELEASE AND ASSIGNMENT:

I agree to be financially responsible for all charges incurred at this office, including my insurance deductible, co-payment and any services rejected by my insurance company. I authorize this office to release any information that is required or necessary for my claim to any insurance company, adjuster, or attorney involved in this case; and hereby release this office of any consequence thereof.

I hereby instruct and direct my insurance company to pay to this office the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this office.

I give this office power of attorney to endorse checks made out to me, to be credited to my account.

(Date)

PATIENT SIGNATURE **X**
(Or Patient Representative) (Indicate relationship if signing for patient)