Payment & Cancellation Policy

In effort to provide you with professional and personalized holistic health care, I reserve your appointment time exclusively for you. I request that you provide a minimum of 24 hours notification if you need to cancel or re-schedule your appointment. **In the event of a missed appointment or an appointment cancelled with less than 24 hours notice you will be charged $75.**

Herbs, nutritional supplements, and natural remedies **cannot be returned** once they are open as I am unable to re-sell them.

A $30 fee will be charged for returned check.

Printed Name of Patient_____

Signature of Patient or Guardian _____ **Date** _____

Complete the section below ONLY if you are claiming insurance.

Authorization to Release Medical Information

To whom it may concern; I, _____, am receiving acupuncture & related treatments from a staff member of Earley Wellness Group. I hereby authorize Earley Wellness Group to release my medical records, to verify information required for processing payment, & to collect payment directly from my insurance company. I understand if my insurance fails to pay for my treatments, or pays me directly, I am responsible for making payments to Earley Wellness Group. I also authorize Earley Wellness Group, to obtain medical information on me as needed.

Patients Name:_____**Date**_____

DOB:_____ **Sex: F / M**

Primary Insured ID # (if other than patient):_____

Primary Insured Name:_____ **Primary Insured DOB:**_____

Primary Insured Employers Name:_____

Signature_____

For office use only.

Co-Pay: $_____ **Deductible**_____

Diagnosis Codes:_____