Brandon Benjamin Acupuncture
3024 NE 63rd Ave, Portland, OR 97213
503-893-8328

OFFICE POLICIES

Welcome to the Acupuncture office of Brandon Benjamin, LAc, LMT. We want you to be comfortable and to receive the best care possible. Please do not hesitate to ask any questions you might have regarding your visit, your billing, or our policies.

PAYMENTS
The fees charged in this office are comparable to those charged by other healthcare providers in this area with similar qualifications. Please ask to see our fee schedule. We accept cash, credit cards, and personal checks. Please note there is a $25.00 charge for checks returned due to insufficient funds.

INSURANCE COVERAGE
Many insurance policies cover Acupuncture, but we do not claim that yours does. Policies can differ greatly in terms of deductible and percentage of coverage for Acupuncture. We can verify coverage and submit your claim form for reimbursement, provided you sign the financial agreement below.

RELEASE OF INFORMATION
Your insurance company may require medical reports to document our treatment and progress. Your initials below authorize the release of medical information necessary to process your claim.

CANCELLATIONS
As a courtesy to our office and other patients, we ask that you please notify the office at least 24 hours in advance if you need to cancel or reschedule your appointment. You will be charged the full amount for any missed appointment or cancellation giving less than 24 hours notice for any non-emergency situations

LATE POLICY
If you are more than 15 minutes late to an appointment, we may not be able to give you a full treatment. We may ask that you reschedule your appointment and pay the full amount for your appointment.

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS
I am receiving or about to receive health care services in this office. I understand that I am responsible to pay all non-insurance related fees when services are rendered, including herbs, etc. If I choose to use my insurance I understand I will be responsible for all “non covered” services and /or coinsurance/co-pays associated with my office visit. In addition I authorize insurance payment of medical benefits to Brandon Benjamin, LAc, LMT.

By signing below, I agree to comply with the office policies stated above which I have read and understood. I also authorize the use of this signature on all insurance submissions.

Patient Name: _____
Patient Signature: _____
Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The privacy of your protected health information is important to us. We have provided you with a copy of our Notice of Privacy Practices. It describes how your health information will be handled in various situations. We ask that you sign this form to acknowledge you received a copy of our Notice of Privacy Practices. This includes the situation where your first date of service occurred electronically. If your first date of service with us was due to an emergency, we will try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

I have received Privacy Practices of Brandon Benjamin, LAc, LMT.

Patient Name: _____
Patient Signature: _____
Date: _____

MEDIATION & ARBITRATION AGREEMENT

If a dispute arises from or relates to this contract or the breach thereof, and if the dispute cannot be settled through direct discussions, the parties agree to endeavor first to settle the dispute by mediation administered by the American Arbitration Association under its Healthcare Payor Provider Mediation Procedures before resorting to arbitration.

The parties further agree that any unresolved controversy or claim arising out of or relating to this contract, or breach thereof, shall be settled by arbitration administered by the American Arbitration Association in accordance with its Healthcare Payor Provider Arbitration Rules and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof.

Claims shall be heard by a single arbitrator. Each party shall bear its own costs and expenses and an equal share of the arbitrator's and administrative fees of arbitration. The place of arbitration shall be Portland, Oregon. The arbitration shall be governed by the laws of the State of Oregon. Except as may be required by law, neither a party nor an arbitrator may disclose the existence, content, or results of any arbitration hereunder without the prior written consent of both parties.

The parties agree that failure or refusal of a party to pay its required share of the deposits for arbitrator compensation or administrative charges shall constitute a waiver by that party to present evidence or cross-examine the witness. In such an event, the other party shall be required to present evidence and legal argument as the arbitrator(s) may require for the making of an award. Such waiver shall not allow for a default judgment against the non-paying party in the absence of evidence presented as provided for above.

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INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that acupuncture and East Asian medicine methods of treatment may include, but are not limited to, traditional and modern techniques of East Asian evaluation and diagnosis, acupuncture, moxibustion, cupping, gua sha, electrical stimulation, infrared therapy, shiatsu, tui na, massage, acupressure, stretching, exercise, qi gong, herbal medicine, vitamins, minerals, dietary and nutritional supplements, dietary advice, health education, breathing and relaxation techniques. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs

are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above 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 agree with the current or future recommendations for care. 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.

Patient Name: _____
Patient Signature: _____
Date: _____