

COLORADO MANDATORY DISCLOSURE STATEMENT

Erin Pass, L.Ac., Dipl. Ac. (NCCAOM), Dipl. C.H. (NCCAOM),

303-665-5515 Phone

David Moats, L.Ac., (NCCAOM), Dip. O.M. (NCCAOM)

303-665-5832 Fax

2500 Arapahoe Avenue, Suite 290, Boulder, CO 80302

Education and Experience:

Erin Pass holds a Master of Science, Oriental Medicine degree (MSOM) from Southwest Acupuncture College, obtained in July 2002. This three-year program consists of 2,823 hours of education including 1262.5 hours of clinical practice. In August 2002, she certified as a Diplomate in Acupuncture and Traditional Chinese Medicine granted by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM). This includes certifications in Clean Needle Technique and Chinese Herbology. Erin's license number is 839. Her license has been held through the Department of Regulatory Agencies since July 2002. None of her licenses, certificates, or registrations have ever been suspended or revoked. Erin's training includes adjunctive therapies such as moxibustion, tuina, acupressure, cupping, and auriculotherapy as well as dietary and lifestyle recommendations. Erin is a member of the Acupuncture Association of Colorado and the American Acupuncture Council.

David Moats earned his Master of Science in Oriental Medicine degree (MSOM) from Southwest Acupuncture College in Boulder, CO. This four-year program consisted of 3,316 hours of education, including 1065 hours of clinical practice. He is certified as a Diplomate of Oriental Medicine (Dipl.O.M.) by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in December 2013. This includes certification in Clean Needle Technique, Acupuncture, and Chinese Herbology. David's training includes adjunctive therapies such as moxibustion, tuina, acupressure, cupping, auriculotherapy, as well as dietary and lifestyle recommendations. David's Colorado license number is 1971.

Fee Schedule: (subject to review each January and July)

Acupuncture:

97810 Acupuncture	\$80
97811 Acupuncture/15 mins	\$25
97813 Acupuncture/Electrostim	\$100
97814 Acupuncture/Electrostim	\$30

Modalities

97026 Heat Therapy	\$25
97112 Tui na/Meridian Therapy	\$55

Evaluation/Office Visits

99211 Office Visit Minimum	\$55
99203 New Patient Routine/Standard	\$90

Herbal prescriptions, patents, and some other products must be paid for at the end of each visit. They are not included in the above listed prices and are separate from insurance billing.

Note: A standard treatment session is 45 minutes long. Treatments requiring more than 45 minutes are billed at the rate of \$100.00/hour.

We ask that you make every effort to notify us as far in advance as possible if you are unable to

This disclosure is in compliance with the State of Colorado, Department of Regulatory Agencies, Colorado Statue Title 12 Article 29.5. All rules and regulations set forth by the Department of Health are strictly adhered to by this clinic, including proper cleaning and sterilization of the equipment and the office.

The practice of acupuncture is regulated by the Department of Regulatory Agencies. Any complaints should be directed to: Director of the Division of Registrations in the Department of Regulatory Agencies: 1560 Broadway, Suite 1545. Denver, CO 80202. Phone 303-894-2464.

Patients are entitled to receive information about the methods of therapy, techniques used, and the duration of therapy, if known. Patients may seek a second opinion and may terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

keep an appointment. **Twenty-four hours notice is required for cancellations.** If less than twenty-four hours notice is given the patient will be charged the full price of their visit. Unless we are billing the patient's insurance, full payment is expected at the beginning of each treatment. With insurance, you will be expected to pay your co-pay (if required) at the time of your visit and a surcharge will be added to any visits requiring billing. Due to the nature of car accident insurance billing and the mailing of payments, we will continue to see a client with a balance only until it is equal to or greater than \$500. At that time, visits will cease until payments are up to date. Please understand that enforcing this policy ensures the continuation and care of our patients and is designed to protect you. In general, if we are not billing your insurance directly, and you wish to apply for reimbursement, we will provide a superbill for you to submit. Worker's compensation does not apply to the above listed schedule. Colorado State Law will be followed for worker's compensation cases.

I have carefully read and understand the above, and agree to the terms of this Client Disclosure Form.

Signature: _____ Date: _____

Consent for Treatment

Name _____ Phone (H) _____ (W) _____

Street _____ Sex _____ Age _____ Height _____ Weight _____

City _____ State _____ Zip Code _____

Birthdate _____ Occupation: _____

Employer's Name _____ E-mail: _____

Marital Status _____ Number of Children _____ Referred by: _____

Personal Physician _____ Date of Last Physical _____

In an emergency contact: _____ Phone: _____

I, the undersigned, an adult over the age of 18, hereby consent to receive acupuncture treatment from the Acupuncture Clinic of Boulder, Inc., Erin Pass, L.Ac., Dipl. C.H. and David Moats, L.Ac., Dipl. O.M.

I am fully aware that the acupuncture needles are sterile and disposable and that no needle used has ever been used on another person.

I fully understand that there is no stated or implied guarantee of success or effectiveness of a specific treatment or series of treatments.

I understand that complications may result from acupuncture treatments. Among these possible complications are: areas of anesthesia, fainting, weakness, nausea, hematoma, bruising, infection, burns, pain and discomfort, pneumothorax, and aggravation of present symptoms.

I understand that acupuncture and Chinese medicine is not a substitute for standard Western medicine, and that certain health disorders may require allopathic diagnosis and treatment. I am free to seek allopathic medical advice and treatment at any time, either in lieu of or concurrently with Traditional Chinese Medicine.

I fully realize that I may withdraw from my treatment at any time.

I understand and agree to hold harmless, to indemnify and protect against court action the individual therapist as well as the management of this clinic, in the event of accidental injury on these premises.

Signature _____ Date _____

Parent or Guardian:

I, the parent or guardian of the above named minor, hereby consent to all the above terms and conditions implied in the above document and hereby give permission for my minor child to undergo acupuncture treatments for the purposes and considerations above expressed.

Parent/Guardian Signature _____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practice

I _____ have received the Notice of Privacy Practices from the Acupuncture Clinic of Boulder, Inc.

X _____ Date: _____

In lieu of patient signature, I, _____ a staff member of the Acupuncture Clinic of Boulder, Inc., state that _____ has been given our current Notice of Privacy Practices.

X _____ Date: _____

Cancellation Policy

Unless cancelled at least twenty-four hours in advance (business day), our policy is to charge for the full price of the visit for missed appointments. We have patients waiting for appointments on our wait list. Your courtesy of a phone call allows us to schedule them. This charge is not covered by or billed to your insurance. If due, please pay at the front desk before your next appointment. Your signature indicates that you understand our policy.

Signature _____ Date: _____

Insurance

Assignment of Benefits:

I hereby assign payment directly to the Acupuncture Clinic of Boulder, Inc., who represent this clinic to Payor Groups for the basic benefits, as well as major medical benefits herein specified and otherwise payable to me, but not to exceed the regular charges for this treatment period. I understand that if this is a motor vehicle accident and the medical benefits are exhausted such that financial responsibility reverts to my health insurance. I am financially responsible for any applicable deductibles or co-pays. I also understand that I am financially responsible for any charges not covered by this assignment. I understand I will be held responsible for any costs incurred regarding collection of payment for services rendered. I will update billing information in writing to the Acupuncture Clinic of Boulder, Inc. as soon as any changes occur in my insurance coverage or address.

Signature: _____ Date: _____

