Deerfield Healing Arts

Acupuncture Therapies • Zero Balancing • Mentoring • Classes in Zero Balancing
www.deerfieldhealingarts.com

Lisa J. Berger, M. Ac.
Licensed Acupuncturist, Dipl. Ac. (NCCAOM)
Certified Zero Balancer and ZB Faculty Member

194 North Main Street
South Deerfield, MA 01373
413-397-9800

PRACTICE INFORMATION AND POLICIES

You, ______________________have made an appointment with me on _______________at _______________ (see enclosed driving directions). On this day, please wear comfortable clothing, be as scent free as possible, and refrain eating a heavy meal before your treatment.

Most appointments are scheduled for 45 minutes and involve 25-35 minutes of treatment according to your response. I may recommend longer or shorter appointments after observing your response to treatment. During the first treatment session, I will spend more time in conversation to clarify your concerns, hear your health history, evaluate your energy patterns, and develop your treatment plan.

Forty-five minute appointments cost $70. Longer or shorter appointments will be priced proportionately. Payments are expected at the time of treatment, unless we make other arrangements. Checks should be made out to Lisa Berger. After the first visit, please tell me if you require a reduced treatment fee in order afford frequent visits.

For those with employee benefits and third party payers, I will provide receipts and statements upon request. Unfortunately most insurance companies either don't cover my services or require documentation and billing procedures that don't fit my practice.

In case you need to reschedule your appointment, I request 48 hours notice in order to realistically offer that time to someone else. Late cancellations (same day or no notice) incur a charge of $35 except in cases of illness, emergency or hazardous driving conditions.

Please sign below and bring this to your appointment. Thank you!

AGREEMENT TO RECEIVE TREATMENT

I understand and agree to the above policies. I authorize Lisa J. Berger, Lic. Ac., to treat me.

Signed_____________________________________ Date_________________

Address_____________________________________ ______________________________________

Phone #s ____E-mail ________________________

If under 18 years of age, treatment for _______________________________ *authorized by:*

________________________________, *relationship*______________ *Date* __________________