

Deerfield Healing Arts

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

Treatments, Time and Fees:

First Appointment Intake & Treatment: (intake, goal-setting, evaluation, treatment, and recommendations for follow-up care) 75-minute appointment, \$115

Healing Arts Consultation & Treatment: (goals, re-evaluation, treatment) 45 minutes, \$85

Zero Balancing One-to-Two Clinic: 20-35 minutes — sliding scale: \$35 – \$25 Held on specific dates at InBody, 265 Greenfield Road, South Deerfield, MA

Self Care Consultations: (in-person or by phone) 30 minutes, \$70

Discounts and Fee Adjustments:

- Treatments for children 16 or under will be \$20 off usual fees. *Note: Brief consultations for young children can be combined with a treatment for a parent.*
- Low-income fee reductions are possible. Please call to arrange.
- Fee discounts can be arranged to make biweekly, weekly or bimonthly visits more affordable for those with financial constraints. Once this period is over, usual fees would apply.

Cancellation Policies:

- I request 48-hours notice in order to realistically offer your time to someone else.
- Late Cancellations (less than 24-hours notice or no notice) will incur a charge of \$50 (\$25-\$35 for ZB Clinic) except in cases of illness, emergency or hazardous driving conditions.

Insurance and Employee Health Benefits:

Currently, the covered benefits, documentation and billing procedures of health insurance companies do not fit my practice. I will provide receipts to those of you who are able to receive reimbursement from your employers.

AGREEMENT TO RECEIVE TREATMENT:

v. 5/2018

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

Print Name: _____ Signature _____ Date _____

Address _____

Phone # _____ Email _____

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

_____, relationship _____ Date _____