Dr. Hao Liu O.M.D.
Hao's Healing Lounge, Inc

Liability Waiver

I, the undersigned (or legally appointed representative thereof), in accordance with the terms and conditions of my fully executed Hao's Healing Lounge, Inc., a California Incorporation (the "Company") Consent to Treatment Form, hereby waive my rights to legal action for any apparent worsening of any and all conditions and/or any symptoms related thereto that may occur during or after acupuncture treatment by any authorized member of the Company. By signing this form, I understand that the Company and/or any of its authorized members or representatives are not, and cannot be, held liable for any deterioration of pre-existing conditions and/or symptoms related thereto, and further, that the Company and/or any authorized member of the Company shall not be held responsible for monetary compensation, loss or damages resulting from further hospitalization and/or subsequent care due to deterioration of any and all conditions and/or symptoms related thereto.

Insurance Disclaimer

Hao's Healing Lounge, Inc. offers to verify with my insurance carrier, however a quote of benefits does not guarantee payment or eligibility. In the event of non-payment, I will be responsible for any co-payment, deductible or coinsurance that applies.

Cancellation/No Show Policy

In order to be respectful of the medical needs of other patients, please be courteous and call Dr. Liu's office promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will allow another patient access to timely medical care.

I hereby acknowledge that I am aware and accept the financial responsibility for fees assessed to my account for failing to provide a 24 hour cancellation notice of any scheduled appointment at Hao's Healing Lounge. The fee will be **$50.^{00}**. I understand that this fee is not reimbursable by my insurance carrier.

Date:__________________________

______________________________	______________________________
Printed Name (Patient)	Signed Name (Patient)
______________________________	______________________________
Printed Name of Representative	Signed Name of Representative

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