INFORMED CONSENT FOR ACUPUNCTURE AND ORIENTAL MEDICINE TREATMENT

I request and consent to the performance of acupuncture and other Chinese medicine procedures. I understand that my signature on this form indicates that I have read the following, and understand that if I have any questions about this information, I should ask the practitioner.

1. **Nature of Treatment**: The treatment modalities may include acupuncture, massage therapy, acupressure, cupping, gua-sha, electric acupuncture, Chinese herbs. I understand that the treatments will be explained to me prior to treatment for my condition.

2**. Purpose of Treatment**: I understand that the purpose of the treatment is to resolve my condition, the reason that I am requesting treatment. The procedures used will attempt to remedy bodily dysfunction or diseases, to modify or prevent the perception of pain, and to make normal the body's physiological functions.

3. **Risks of Treatment**: I understand that Chinese medicine procedures have been shown to be safe and effective. However, I understand that there are some uncommon risks. These may include:

- Mild discomfort during or after the insertion of a needle, dizziness, fainting, localized bruising or swelling, gastro-intestinal upset with the use of Chinese herbs, temporary aggravation of symptoms that existed prior to treatment; Some herbs and acupuncture points are contra-indicated during pregnancy. Please notify your practitioner if you **are or might** be pregnant.

4**. Use of Disposable Needles**: I understand that to prevent any possibility of infection from acupuncture, all needles used are pre-sterilized, one time use, surgical stainless steel needles that are disposed of after usage as medical waste. Needles are never reused.

5. **Unforeseen risks**: I understand that the practitioner cannot anticipate or explain all risks and complications which may occur during or after treatment. I understand that they will exercise judgment based upon their determination of my best interests. I understand that I may stop treatment at any time.

PAYMENT & APPOINTMENT POLICIES

PAYMENT POLICIES:

If my insurance does not pay for the treatment services, I agree to pay for them myself. Also, I agree to pay co-payments, deductibles, and/or coinsurances for treatment services as required by my policy.

ASSIGNMENT OF BENEFITS

I authorize the insurance company to make payment to the practitioner for my treatments and services.
I authorize release of information concerning my (or my child's) health care, advice and treatment provided only for the purpose of evaluating and administering claims for insurance benefits.

APPOINTMENT POLICIES:

Please be on time for appointments. Failure to cancel an appointment with less than 24 hours notice will result in a $40.00 charge. Please note that your insurance carrier is not responsible for this fee, you are. This policy is in place out of respect for our time and our patients - by giving more than 24 hours notice, you allow time for us to adjust the schedule for waitlisted patients and other needs.

HIPPA PRIVACY ACT ensures that all of your personal and health information remains confidential at all times between this office, your insurance company and you only. Should you have any questions about the privacy of your information at this office, you may ask Jenny Johnston at any time.

Your signature indicates that you have read, understand and agree with the above information.

Signature of patient (or parent if minor) _____ Date _____

Notice of Privacy Policy

Acupuncturists, like all providers of professional medical services, are required by law to inform their clients of their policies regarding privacy of patient information. This clinic is bound by very high professional standards of confidentiality. Protecting your privacy and your healthcare information is fundamental in the course of our relationship. *This notice will remain in effect until it is replaced or amended by changes in law.*

Information that we receive from you, other healthcare providers and/or third party payers is used for your treatment, payment of your bill and our healthcare operations. You may specifically authorize us to use protected health information or to disclose your health information by submitting the authorization in writing to us.

We may need to share limited personal medical and financial information with your insurance company, with Worker's compensation, and/or your employer if required, or with other medical practitioners that you authorize. This clinic will not use your health information for marketing purposes without your written authorization. We may, however, send you newsletters, appointment reminders, and important clinic updates by telephone, email, or mail.

Disclosure

When required by law, this office may use or disclose your protected health information

Patient Rights

1. Upon written request you have the right to access, review or receive copies of your healthcare records. There is a copy fee (minimum of $15 or legal amount) and 10 working days for us to process this request
2. Upon written request, you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your protected health information.
4. You have the right to request in writing that we amend your protected health information
5. You have a right to receive all notices in writing.

If you have questions, complaints, or want more information, please contact this office. You may send written complaints to the U.S. Department of Health and Human Services.

Acknowledgement of Receipt of Notice of Privacy Practices

I have received, read, reviewed, understand my rights and agree to the statement of the Privacy Policy for healthcare services in this clinic. By way of my signature below, I provide *Jenny Johnston, L.Ac.* with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice.

Patient Signature: _____ Date: _____