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Consent to Services

Services to be Provided

Treatments may include the insertion of sterile needles, bodywork, gua sha (rubbing of the skin with a smooth object), cupping (the application of glass cups with vacuum to the skin) and/or the application of heat to the skin. I understand that I may refuse any of these techniques at any time.

Risks/Possible Side Effects

Treatment may result in certain side effects, including burns, local bruising, slight bleeding, fainting, temporary pain and discomfort, and temporary aggravation of symptoms existing prior to treatment. Extremely rare risks include pneumothorax and spontaneous miscarriage.

No Guarantees

Acupuncture serves individuals with a wide range of complaints including both acute and chronic healthcare issues. I acknowledge that I have not received any guarantees or promises as to the results from the services provided.

Client Responsibilities

It is my responsibility as a client to inform my acupuncturist of all aspects of my health and that, as service progresses, to inform my acupuncturist of changes that occur. I will inform my acupuncturist if I am pregnant and/or suspect pregnancy at any time. If I experience any pain, discomfort or possible adverse side effects, it is my responsibility to immediately notify my acupuncturist.

Medical Treatment

An acupuncturist is not a substitute for a medical doctor and will not suggest that I discontinue medical treatment. I understand that if I am currently under a physician's care, I should continue as long as my physician deems necessary. It is my responsibility to consult with my physician before altering any prescribed medications or treatments. I understand also that if there is an emergency, or a worsening of my health condition, or if a new condition arises, that I should consult a licensed physician.

Fees and Charges

I have been informed of the fees for service, and I understand that payment is due when the services are provided. If I do not cancel an appointment by phone at least 24 hours in advance, then I am liable for the full amount of the missed appointment.

I have read and understand the information in this form and I understand the possible risks and complications involved. I have had the opportunity to ask questions regarding the proposed services, this form, and have received satisfactory explanations. I understand that I can request more information at any time if desired. I understand that I have the right to refuse or discontinue any treatment at any time. I understand that this refusal may affect the expected results. I hereby voluntarily consent to acupuncture treatment.

_____
Patient Name

_____ _____
Patient Signature (or parent or guardian if client is a minor) Date

Notice of Privacy Practices

Health Insurance Portability and Accountability Act (HIPAA) requires that healthcare professionals give their clients a Notice of Privacy Practices and that clients sign in acknowledgement that they received the notice.

During your course of treatment, I will use and disclose your Protected Health Information only for treatment, payment and when required by law. Furthermore, you will be contacted when necessary using the phone number and address you have provided unless you specifically request otherwise.

Upon written request:

- You have the right to review or obtain copy of your health record from me. You have the right to request that we amend your Protected Health Information.
- Your Protected Health Information is kept confidential and not shared with anyone else unless you sign a separate consent form for the release of information.
- You have the right to request additional restrictions on the use and disclosure of your Protected Health Information.

If you have any questions about your rights or believe your privacy rights have been violated, please let me know. You also have the right to file a complaint with the U.S. Secretary of Health and Human Services (Office of Civil Rights: 1-800-368-1019) with no fear of retaliation.

I acknowledge I have received and understand this Notice of Privacy Practices.

_____
Signature