Notice of Patient Privacy

Health Insurance Portability and Accountability Act (HIPPA) Effective Date: April 14, 2003 Revised: October 22, 2015

Life Force Acupuncture is dedicated to preserving your "Protected Health Information" (PHI). We are required by law to protect your health information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all protected health information maintained by us. This Notice of Privacy Practices describes your rights and Life Force Acupuncture and Wellness's responsibilities with respect to your Protected Health Information. You may receive a copy of any revised notices at Life Force Acupuncture and Wellness. Life Force Acupuncture and Wellness may use or disclose your PHI for the purpose of providing medical treatment, obtaining payment for health care bills or to conduct health care operations. We may be required by law to use and disclose your medical information for other purposes without your consent or authorization. Your PHI means health information, including your demographic information, collected by us, other health care providers, a health care clearinghouse, or an employer. This protected medical and health care information relates to your past, present or future physical or mental health or condition and identifies you, or there is a reasonable basis to believe the information may identify you. You are provided the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, request that we restrict certain uses and disclosures of your health information, and file a complaint if you think your rights have been violated. All requests and complaints must be made in writing. You have the right to receive a copy of our most current NOTICE in effect, please ask if you wish to receive it. We have available a detailed NOTICE OF PRIVACY PRACTICES (long form) which fully explains your rights and our obligations under the law. You have the right to receive a copy of our most current NOTICE in effect, please ask and we will provide you with a copy. We may revise our NOTICE from time to time. The Effective Date at the top right hand side of this page indicates the date of the most current NOTICE in effect.

By signing this form you are acknowledging that you have been provided information regarding our privacy practices pertaining to your "Protected Health Information."

READ, UNDERSTOOD AND AGREED PATIENT

PATIENT SIGNATURE X	DATE

(OR PATIENT REPRESENTATIVE) INDICATE RELATIONSHIP IF SIGNING FOR THE PATIENT_____

Please keep in mind that we require 24 hours notice to cancel appointments.
Missed appointments without 24 hour notice are subject to a $45 missed appointment fee.

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE X

(Or Patient Representative) (Indicate relationship if signing for patient)