SIERRA ACUPUNCTURE & HEALING ARTS

PRIVACY INFORMATION – HIPPA Compliance

To insure your privacy, please answer the following question:

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

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Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name______________________ Phone #__________________
Name______________________ Phone #__________________

Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

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Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":

Yes__________ No__________

Please print the telephone number where you want to receive calls about your appointments or other health care information if other than your home phone number:__________

***I am fully aware that a cell phone is not a secure and private line.**

Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail?

Yes__________ No__________

______________________________ (guardian if under 18 years)
Patient Name

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Patient/Guardian Signature

____
Date

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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 above 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 above, including those working at the clinic or office listed above 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, nutritional counseling, botanical medicine, cosmetic acupuncture, JMT, homeopathy, IFR heat, gua sha, and acupuncture injection therapy. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs, or any nutritional/botanical supplement. I have been informed that acupuncture and acupuncture injection therapy are generally safe methods 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 and injection therapy. 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, at all times.

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.

_______________________________________ ***DATE***__________________

PATIENT SIGNATURE

Non-Covered Medicare

The practitioners of Sierra Acupuncture & Healing Arts are not Medicare providers or affiliated with Medicaid. Thus Medicare and Medicaid **does not** cover expenses associated with treatments rendered at Sierra Acupuncture & Healing Arts. Medicare **does not** cover O.M.D.'s to perform acupuncture and there is no guarantee that your secondary insurance will cover. As a courtesy, we will bill your secondary insurance if we are named as a provider for that insurance, and there is no guarantee that your secondary insurance will cover. As a courtesy, we will bill your secondary insurance if we are named as a provider for that insurance. If we do not receive payment within 60 days, you will be responsible for payment in full for your outstanding balance.

**** By signing this document, I acknowledge that I am aware and will follow these policies.**

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Patient Signature or Guardian

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Date