Cape Fear Community Acupuncture

Patient Consent Form

PATIENT NAME: ______________________________ DATE: ______________

- Due to the possibility of herb/drug interactions, we require that patients inform us of any medication use. This includes prescriptions, over-the-counter medications, herbs, vitamins and other supplements.

- As acupuncture and herbal treatment can affect pregnancy, we need to know if there is any possibility that you are pregnant.

- Acupuncture treatment is performed using sterile, disposable, single-use needles. Side effects of acupuncture occasionally include, but are not limited to, local bruising, minor bleeding, fainting, temporary pain, and a possible temporary aggravation of symptoms.

- We maintain the confidentiality of patient information at all times.

- We may refer patients to Medical Doctors or other practitioners for assessment and/or treatment as necessary.

- **24-hour notice requested when making a cancellation or rescheduling an appointment. We reserve the option to charge patients or their insurance company for missed appointments.**

I have read, understand and will comply with the above statements:

Patient Signature: ______________________________ Date: ______________

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 named 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 be 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.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and 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 **X**

(Or Patient Representative)

(Indicate relationship if signing for patient)

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Cape Fear Community Acupuncture

NOTICE OF PATIENT INFORMATON PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

Cape Fear Community Acupuncture's LEGAL DUTY

Cape Fear Community Acupuncture is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Cape Fear Community Acupuncture uses your personal health information and may disclose this information primarily for providing treatment and continuity of care; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, *Cape Fear Community Acupuncture* may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Cape Fear Community Acupuncture may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, *Cape Fear Community Acupuncture's* policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Cape Fear Community Acupuncture may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request and updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. *Cape Fear Community Acupuncture* will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

Cape Fear Community Acupuncture

HIPAA

Patient Information Acknowledgement

I have read and fully understand *Cape Fear Community Acupuncture*'s Notice of Patient Information Practices. I understand that *Cape Fear Community Acupuncture* may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that *Cape Fear Community Acupuncture* will consider requests for restriction on a case-by-case basis.

I hereby acknowledge to the use and disclosure of my personal health information for purposes as noted in *Cape Fear Community Acupuncture*'s Notice of Patient Information Practices. I understand that I reserve the right to revoke this acknowledgement by notifying the practice in writing at any time. I hereby acknowledge that I have received a copy of the Notice of Patient Information Practices.

____________________________ __________________________ ____________

Patient Name (Print) Patient/Guardian Signature Date

Designated Individuals Authorization

I hereby authorize one or all of the designated parties below to request and receive the release of protected health information regarding my treatment, payment or administrative operations related to treatment and/or payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

____ __________________________

Print Name Relationship

____ __________________________

Print Name Relationship

____ __________________________

Print Name Relationship

______________________________ ____________

Patient/Guardian Signature Date