Green Point Acupuncture

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 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 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.

Green Point Acupuncture

FINANCIAL POLICY AGREEMENT

1. This is a Financial Policy Agreement for *Green Point Acupuncture L.L.C.* (hereinafter referred to as "the clinic"), and serves as an agreement with the undersigned (hereinafter referred to as "patient").

2. **The clinic provides acupuncture treatment to you, the patient. Payment is expected at the time of treatment, from patient, for all services and herbal prescription items, or when prescription is rendered, unless arrangements are made with the patient's health insurance company.**

3. Some insurance policies offer full or partial coverage for acupuncture care. In the case of practitioners not being the preferred providers, patient must make payment for all services and prescription items at the time service or the herb prescription is rendered. The clinic will provide the appropriate forms and codes for patient to file with the insurance company. **In the case of the practitioners being the preferred provider in a health insurance plan, patient must pay copay, deductible, coinsurance, or non-covered herbal supplements or other non-covered items at the time of the service.** In the case of insurance company denying a claim for coverage due to any reason, the patient is then responsible for all unpaid balances incurred.

4. If the patient's bank or financial institution returns a check for any reason, a handling fee of **$40.00** will be assessed for each time the check is returned by the bank or financial institution.

5. The clinic reserves the right to bill patient's bank or other negotiable instruments in the event of a delinquent account. Patient authorizes payment of delinquent account with bankcard, or other instrument.

6. Patient must inform the clinic of any changes in their appointment at least 24 hours ahead of time or a fee of **$40.00** will be charged.

Green Point Acupuncture

NOTIFICATION OF QUALIFICATIONS AND SCOPE OF PRACTICE

East Asian medicine means a health care service using East Asian medicine diagnosis and treatment to promote health and treat organic or functional disorders.

1. Our qualifications:

   (a) Both Dr. Weihua Wang and Dr. Guoji Wu graduated from Beijing University of Chinese Medicine with a major in acupuncture. Dr. Wang worked for ten years in China as a clinical doctor of acupuncture, successfully treating a wide range of conditions. Dr. Wu applied his doctorate in acupuncture to ten years of research into acupuncture as analgesia.
   (b) Both Dr. Weihua Wang and Dr. Guoji Wu have licenses as East Asian medicine practitioners (licensed acupuncturists) in Washington State.

2. Our scope of practice at Green Point Acupuncture L.L.C. includes the following:

   (a) Acupuncture, including the use of acupuncture needles to directly or indirectly stimulate acupuncture points and meridians;
   (b) Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians;
   (c) Moxibustion;
   (d) Acupressure;
   (e) Cupping;
   (f) Infra-red;
   (g) Dietary advice and health education based on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements;
   (h) East Asian massage and Tui na, which is a method of East Asian bodywork, characterized by the kneading, pressing, rolling, shaking, and stretching of the body. It does not include spinal manipulation.

3. Side effects may include, but are not limited to:
   (a) Pain following treatment;
   (b) Minor bruising;
   (c) Infection;
   (d) Needle sickness; and
   (e) Broken needle.

4. The patient must inform the East Asian medicine practitioner if the patient has a severe bleeding disorder or pace maker prior to any treatment.

Green Point Acupuncture

NOTIFICATION OF PRIVACY PRACTICES

This Notification of Privacy Practices (*Notification*) describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review carefully.

Green Point Acupuncture L.L.C. respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For examples, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relation to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations

For treatment

- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing you care. This will help them stay informed about your care.

For payment

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.

For health care operations

- We use your medical records to assess quality and improve services.
- We may use and disclose medical record to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may contact you to raise funds.
- We may use and disclose your information to conduct or arrange for services, including:
    - Medical quality review by your health plans;
    - Accounting, legal, risk management, and insurance services;
    - Audit functions, including fraud and abuse detection and compliance programs.

Your Health Information Rights

The health and billing records we create and store are the property of the practice/health care facility. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this *Notification*;
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request. But we will comply with any request granted;
- Request and receive from us a paper copy of the most current Notification of Privacy Practices for Protected Health Information;

- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information—except in certain circumstances;
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third-party payers. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights during normal business hours, please contact:
Weihua Wang, our privacy officer
Phone: (206) 313-0961

Our Responsibilities

We are required to:
- Keep your protected health information private;
- Give you this *Notification*;
- Follow the terms of this *Notification*.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this *Notification*. You may receive the most recent copy of this *Notification* by calling and asking for it or by visiting our office to pick one up.

To Ask for Help or Complain

If you have questions, want more information, or want to report a problem about the handing of your protected health information, you may contact:
Weihua Wang, our privacy officer
Phone: (206) 313-0961

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to Weihua Wang, our privacy officer, at our patient/health care facility. You may also file a complaint with the U.S. Secretary of Health and Human Services.

We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Other Disclosures and Uses of Protected Health Information

Notification of Family and Others
- Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. In addition, we may disclose health information about you to assist in disaster relief efforts.
- [Hospitals] Information may be provided to people who ask for you by name. We may use and disclose the following information in a hospital directory:
    - your name
    - location,
    - general condition, and

- religion (only to clergy).

You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

We may use and disclose your protected health information without your authorization as follows:

- **With Medical Researchers**—if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **To Funeral Directors/Coroners** consistent with applicable law to allow them to carry out their duties.
- **To Organ Procurement Organizations** (tissue donation and transplant) or persons who obtain, store, or transplant organs.
- **To the Food and Drug Administration (FDA)** relating to problems with food, supplements, and products.
- **To Comply with Workers' Compensation Laws**—if you make a workers' compensation claim.
- **For Public Health and Safety Purposes as Allowed or Required by Law**
  - To prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
  - To public health or legal authorities
    - To protect public health and safety
    - To prevent or control disease, injury, or disability
    - To report vital statistics such as births or deaths.
- **To Report Suspected Abuse or Neglect** to public authorities.
- **To Correctional Institutions** if you are in jail or prison, as necessary for your health and the health and safety of others.
- **For Law Enforcement Purposes** such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- **For Health and Safety Oversight Activities**. For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- **For Work—Related Conditions That Could Affect Employee Health**. For example, an employer may ask us to assess health risks of a job site.
- **To the Military Authorities of U.S. and Foreign Military Personnel**. For example, the law may require us to provide information necessary to a military mission.
- **In the Course of Judicial/Administrative Proceedings** at your request, or as directed by a subpoena or court order.
- **For Specialized Government Functions**. For example, we may share information for national security purposes.

Other Uses and Disclosures of Protected Health Information

Uses and disclosures not in this *Notification* will be made only as allowed or required by law or with your written authorization.

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ACKNOWLEDGEMENT

By my signature below I _____ (patient name), acknowledge receipt of the

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FINANCIAL POLICY AGREEMENT

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NOTICE OF PRIVACY PRACTICES

and agree to all conditions of the agreement contained. I authorize the clinic to release appropriate billing information required for the filing of insurance claims.

PATIENT SIGNATURE _____ DATE _____
(Or Patient Representative. Indicate relationship if signing for patient)

CLINIC SIGNATURE _____ DATE _____

This form will be retained in your medical record.