



INFORMED CONSENT FOR ACUPUNCTURE TREATMENT

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physiotherapy on me (or on the patient named below, for whom I am legally responsible) by Jaclyn Engelsher, Certified Acupuncturist at Jing Acupuncture & Oriental Medicine LLC.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese Acupressure massage), Chinese herbal medicine, and nutritional counseling. I understand that prescribed herbal therapy 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 consumption of the herbs.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to alleviate symptoms of certain diseases or dysfunctions of the body. I have had the opportunity to discuss with the acupuncturist the nature and purpose of acupuncture treatments and other procedures.

I have been informed that acupuncture is a safe method of treatment, but occasionally there may be residual side effects including bruising, numbness or tingling near the insertion sites that may last for an indeterminate period of time, discomfort, fatigue, euphoria, dizziness, fainting, or nausea. Bruising is an expected side effect of cupping. Burns and/or scarring are a potential risk of moxibustion and cupping. Unusual risks of acupuncture include spontaneous miscarriage, pneumothorax, organ puncture, and infection, although this clinic uses sterile, disposable needles and maintains a clean and safe environment.

The herbs that may be recommended are traditionally considered safe in the practice of Chinese Medicine, but some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify the clinical staff member who is caring for me if I am pregnant or planning to become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all risk 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 feels at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand that acupuncturists practicing in the Commonwealth of Kentucky are not performing a medical service as a primary health care provider. I understand that no member of the clinical staff at Jing Acupuncture & Oriental Medicine LLC serves as my primary healthcare provider. I certify that I am currently under the care of a licensed allopathic primary healthcare provider and have agreed to disclose medical information if I have the following conditions: hypertension, cardiac conditions, acute or severe abdominal pain, neurological changes, unexplained weight gain or loss of 15% or greater in the past three months, suspected fracture or dislocation, suspected systemic infection, serious hemorrhagic disorder, acute respiratory distress without previous history, pregnancy, diabetes, and cancer.

I understand the clinical and administrative staff may review my medical 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 certify that I have read, or have had read to me, the above consent to treatment, have been told of the risks and benefits of acupuncture and other procedures, have discussed the nature and purpose of treatment, and have had an opportunity to ask questions. I submit that I have voluntarily chosen to receive treatment involving the above named procedures and agree to indemnify and hold harmless the acupuncturist and facility from any claims. I intend this consent form to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.

Name of Patient (please print)

Patient's Representative, if necessary

Patient's Signature

Relationship to Patient

Date Signed



FINANCIAL POLICY

Payment

Payment is due at time of service. Payment plans may be arranged prior to receiving treatment. We do not offer refunds for services rendered.

Cash

We accept cash payments

Checks

We accept personal, business, health savings, and flexible spending checks. The return check fee is \$25 plus \$5 for every 30 days past due. We reserve the right to refuse payment by check from individuals with one or more bounced checks.

Credit and Debit Cards

We accept Visa, Mastercard, and Discover. A credit card is required to hold initial appointments and will be charged according to the cancellation and no/call no show policy (below).

Flexible Spending and Health Savings Accounts

Acupuncture is a covered expense and you may use your FSA/HSA debit card or checks.

Insurance

We do not bill insurance directly. Upon request, we will provide you with a superbill statement with the appropriate diagnosis and procedure codes so your insurance company can directly reimburse you according to your policy. It is your responsibility to check with your insurance company to determine your coverage.

Packages/Gift Cards

Treatment packages are available. All treatments in the package or gift cards are non-transferable, non-refundable and must be completed within a year of the purchase date.

Late Arrival

Appointments are scheduled every 45-60 minutes. Please call if you will be late. We will do our best to accommodate late arrivals within the allotted session time.

Cancellation and No Call/No Show

We offer online appointment scheduling and cancellation. An email appointment reminder will be sent the day before your appointment. Cancellations less than 24 prior to appointment hours are subject to 50% of the treatment fee. The full fee for treatment will be assessed for no call/no show appointments. A credit card may be required to hold future appointments and will be charged according to the cancellation and no/call no show policy.

Signature: _____ Date: _____



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This notice summarizes how health data about you may be used and shared and how you can get access to this data. **IMPORTANT NOTE:** This does not include all of the details about our privacy policy. For more details, please read the NOTICE OF PRIVACY PRACTICES.

I. How we may use and share health data about you:

- a) Treatment - To give you medical treatment or other types of health services.
- b) Payment - To bill you or a third party for payment for services provided to you.
- c) Health Care Operations - For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:

- a) To you
- b) As required by federal, state, or local law
- c) If child abuse or neglect is suspected
- d) Public health risks (for public health activities to prevent and control spread of disease)
- e) Lawsuits and disputes (in response to a court or administrative order)
- f) Law enforcement (to help law enforcement officials respond to criminal activities)
- g) Coroners, medical examiners and funeral directors
- h) Organ or tissue donation facilities if you are an organ donor
- i) To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:

- a) Patient directories - You can decide what health data, if any, you want to be listed in patient directories.
- b) Persons involved in your care or payment for your care - We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:

- a) Right to inspect your health record and to receive a copy of your health record upon request
- b) Right to amend information in your health record you believe is inaccurate or incomplete
- c) Right to know to whom we have disclosed your health information
- d) Right to ask for limits on the health information data we give out about you
- e) Right to receive communication from us about your health information in alternate ways
- f) Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of this practice.

Signature of patient or representative

Date

Print patient name

Patient Birth Date