Whitney Green Acupuncture
7405 SW Beveland Rd | Tigard, OR 97223
(503) 746-6095 | fax: (503) 746-6405
info@whitneygreenacupuncture.com

ACUPUNCTURE INFORMED CONSENT TO TREATMENT

I understand that I am the decision maker for my health care. Part of Whitney Green Acupuncture's (WGA) role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

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 WGA and the licensed acupuncturists who now or in the future treat me while employed by, working or associated with WGA, 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 WGA of any unanticipated effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: 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, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile single-use 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. I will notify WGA if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect WGA to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on WGA to exercise judgment during the course of treatment which WGA thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, WGA of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand WGA 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.

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I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm 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 agree with the current or future recommendations for care. 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.

_____ _____

Print Name Date

_____ _____

Signature or Signature of Authorized Representative If a representative, state your relationship to the individual receiving treatment

PRIVACY POLICY; COMMUNICATION OF INFORMATION; INSURANCE RELEASE; ASSIGNMENT OF BENEFITS; AND FINANCIAL RESPONSIBILITY

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PRIVACY POLICY: I acknowledge that I have received Whitney Green Acupuncture's ("WGA") Notice of Privacy Policy (the "Privacy Notice"). I understand that protected health information may be disclosed or used for treatment, payment, or health care operations. I understand that I have the right to request a restriction as to how my protected health information is used or disclosed. WGA is not required to agree with this restriction in most circumstances (as more fully set forth in the Privacy Notice), but if we do agree to a restriction, we shall honor that agreement to the extent permissible by law. WGA reserves the right to change the Notice of Privacy Policy.

COMMUNICATION OF INFORMATION: I □ do / □ do not (check one) agree that WGA may leave a message on my personal telephone messaging system that includes medical information.
Additionally, I □ do / □ do not (check one) agree that WGA may provide medical information to the following person(s):

_____	_____
Name	Contact Information
_____	_____
Name	Contact Information

INSURANCE RELEASE: I authorize WGA's to release any information necessary to process medical claims.

ASSIGNMENT OF BENEFITS: I authorize my insurance/benefits carrier(s) to remit payment of benefits for any claim to WGA's. I understand that any ineligible/not covered charges are my responsibility.

FINANCIAL RESPONSIBILITY: For and in consideration of the treatment, I promise to pay all charges for services rendered to or on my behalf, with such payment and any copay due at the time of treatment unless and only to the extent insurance is to be billed. If the assigned insurance denies payment, I promise to pay the balance due upon notification. I understand that all products and supplements purchased from WGA are non-refundable. Any balance that remains unpaid in the excess of 60 days will be referred to collections for accounts receivable assistance. I will bear the cost of collection and/or court costs and reasonable legal fees should this be required.

MISSED APPOINTMENT: Our cancellation policy requires 24 hours notice to reschedule or cancel an appointment. Missed appointments or failure to cancel or reschedule at least 24 hours prior to your appointment will result in a $50 fee. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

INSURANCE BILLING: We may accept assignment of insurance benefits at our discretion if acceptable insurance identification is provided. All services provided to you are subject to co-pays, deductible, co-insurance and prior approval in some cases. As a courtesy to our patients, verifiable and assignable insurance will be billed by this clinic. All insurance payments such as co-pays, coinsurance, and deductible payments will be billed to you once your insurance processes the claim, which usually takes 30 days or more. Please remember that your insurance coverage is a contract between you and your insurance company, and not a substitute for payment. You are liable for all charges for services. In the event that any

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changes occur in your health plan, immediately notify this provider. Verification of benefits is a courtesy provided by our clinic and not a guarantee of benefits. Ultimately it is up to the patient to know and understand their policy information at the time that they receive services.

Card on File: I □ do / □ do not (check one) agree that WGA may keep a card on file (HSA, Credit, Debit).
I understand that my card will be charged for the cost of my appointment and any products I may have purchased within 1-2 business days of the appointment or purchase. If I am having WGA bill my insurance policy, I understand that I will receive an invoice for any additional charges from my insurance claims via email and I am responsible for payment via invoice within 7 business days. I understand that if I have not paid the invoice by 7 business days, WGA will charge the card I have on file.

If I have chosen not to keep a card on file, I understand that I must pay in full at the time services are rendered.

All parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

_____ _____
Print Name Date

_____ _____
Signature or Signature of Authorized Representative If a representative, state your relationship to the individual receiving treatment