ACUPUNCTURE
BODYWORK

Hello and welcome to Acupuncture Bodywork. We know there is a lot of information here in the file, but please patiently read through it all and sign where needed. This will be the only time you will have to do this and the rest is pure relaxation!

PAYMENT

Payments are due at the time of treatment. Cash and credit cards are accepted.

Please note packages and gift certificates are non-refundable and expire one year from date of purchase.

We are now able to process insurance claims on your behalf, if you have benefits. However, you are still liable for payment if your insurance company denies payment on a claim or does not pay within two months of date of treatment. Also, please note you may be responsible for a deductible and/or co-pays for each session.

CANCELLATIONS

Please note we have a 24 hour cancellation policy. If you do not cancel within this time frame, we reserve the right to charge you for that visit. A credit card must be on file to secure appointments.

CC type _____ Card #_____ Exp. Date_____

Date _____ Signature _____

PATIENT ADVISORY TO CONSULT A PHYSICIAN

New York State law requires that we advise you to consult a physician regarding any condition or conditions for which you are seeking acupuncture or herbal treatment. These modalities have a lot to offer as a healthcare system, but they are not a substitute for the resources available through a biomedical physician.

The undersigned affirms that _____ (patient) has been advised by Maureen Tetelman to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

RELEASE OF INFORMATION

By signing this form you are also authorizing this office upon request from your insurance carrier the release of any medical or other information necessary to process the claim. You also acknowledge and request payment of government benefits either to myself or to the party who accepts assignment, namely this office.

INFORMED CONSENT

I consent to acupuncture treatments and related procedures associated with Oriental Medicine at Acupuncture Bodywork PC. I have discussed the nature and purpose of my treatment with her and I understand that the methods of treatment may include but are not limited to acupuncture, moxibustion, cupping, gua sha and electrical stimulation.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects including bruising, numbness or tingling near the needle sight, which may last a few days. An unusual risk of acupuncture includes spontaneous miscarriage, nerve damage and organ punctures. Infection is another possible risk, however since this office uses only sterilized, disposable needles while maintaining a clean and safe environment, this is unlikely. Burns and scarring are potential risks of using moxibustion.

I will notify the acupuncturist who is caring for me if I become pregnant or have had any significant medical changes.

By voluntarily signing below, I show that I have read or have had read to me, this consent to treatment. I 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 both the present condition and for any future conditions for which I seek treatment(s).

_____ _____

Signature of patient or patient representative Date

HIPPA NOTICE

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this notice describes how health information about you as a patient of this practice may be used and disclosed and how you can get access to your protected health information.

A. Our practice is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time. The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices.

B. Intake forms including demographic date, insurance information, consents for treatment and medical disclosure will be completed by every patient as part of his/her record. Our office may use and disclose this PHI in order to bill and collect payment for the services you receive from us.

C. Employees and staff are required to sign a confidentiality agreement regarding any information they are exposed to in the office setting which is not to be discussed or revealed to any persons or businesses outside of the office setting without the prior written consent by the patient or legal guardian.

D. Any paper trash with patient information will be shredded prior to discarding it.

E. Medical release forms are required to be signed by the patient or legal guardian in order to release any medical information to themselves, medical offices, insurance companies, or to any other desired location. There may be a reasonable cost-based fee for photocopying, postage and preparation.

F. Our office may contact you for appointment reminders and announcements about our office and staff.

Patient's Printed
Name:_____

Patient's Signature:_____
Date:_____