Sanctuary Community Acupuncture www.AcupunctureForAllSA.com
1112 South Saint Mary's Street
San Antonio, Texas 78210 *(210) 912-4766*

PRIVACY NOTICES

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I understand I have a right to review the "Notice of Privacy Practices" prior to signing this document. The "Notice of Privacy Practices" describes the types of uses and disclosures of my Protected Health Information that will occur in my treatment, payment of my bills or in the performance of health care operations. "The Notice of Privacy Practices" is available upon request. This Notice of Privacy Practices also describes my rights and Jennifer Gwin's duties with respect to my Protected Health Information.

NOTIFICATION OF PATIENT AND HEALTH CARE INFORMATION AUTHORIZATION

The office might contact you for a variety of reasons including appointment reminders, birthday wishes, thank you cards, or promotions at your home, office or cell number via voice message, text message or email.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Due to the Federal HIPAA Regulations enacted in April of 2003, your health care practitioners are not allowed to release any information concerning you or appointments without your written consent. Therefore, if you are interested in having someone other than yourself schedule or cancel appointments for you, pick up your herbal prescriptions, or be informed about any aspect of your treatment, you must list their names on the lines below giving us your authorization to communicate with a third party about your information. This written authorization is also necessary for insurance companies seeking knowledge about your treatments to reimburse a claim, or if you wish to have your case discussed with other doctors or practitioners outside my practice.

Please know my authorization to communicate about your treatment is limited only to those people you have listed on this form. I cannot release any information to anyone not listed on your medical records release form. If, at any time, you need to add to or amend this form please see a front desk receptionist.

I hereby authorize Jennifer Gwin and other associated practitioners the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/Organizations receiving the information: (please print)

_____

_____

Printed name: _____

Patient signature X_____Date_____

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CANCELLATION POLICY

_____ (initial) I have read the cancellation policy and understand that I if I do not show up to my scheduled appointment that I will be charged the full fee.

GETTING ACUPUNCTURE IN TEXAS

In Texas, Licensed Acupuncturists are allowed to treat the following conditions without any prior evaluation or referral requirements. If you are coming for one of these things, indicate this with a checkmark, skip the next section and sign at the bottom.

□ Alcoholism
□ Substance Abuse
□ Smoking addiction
□ Chronic pain
□ Weight loss

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If you are coming for anything else, please fill out the following state-prescribed form below:

NOTIFICATION FORM REGARDING EVALUATION of PATIENT by PHYSICIAN
(Pursuant to the requirements of 22 TAC §183.7 of the Texas State Board of Acupuncture Examiners' rules)

I (printed patient's name) _____, am notifying Sanctuary Community Acupuncture of the following:

(CHECK ONE "YES" ONLY)

□ Yes □ No I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

OR

□ Yes □ No I have received a referral from my chiropractor within the last 30 days for acupuncture. After being referred by a chiropractor, if after two months or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

Patient Name (printed) _____

Patient Signature_____ Date_____

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INFORMED CONSENT TO TREATMENT

I, the undersigned, hereby request and consent to treatment by acupuncture and/or other procedures within the scope of the practice of acupuncture. This may include cupping, Gua Sha (scraping), moxabustion and light bodywork. I am hereby informed that the treatment methods are all generally safe but that there may be some side effects or risks, as follows:

Acupuncture may potentially cause temporary bruising, swelling, bleeding, numbness and tingling, or soreness at the site of needling. Highly unlikely risks of acupuncture include lung puncture (pneumothorax), nerve damage, organ puncture, and infection -although Sanctuary Community Acupuncture Clinic uses only sterile, disposable needles and maintains a clean and safe environment. Acupuncture can cause aggravation of symptoms existing prior to treatment and appearance of new symptoms. Common side effect of cupping and gua sha are temporary bruising and redness lasting a few days, and possible blistering.

The herbal and nutritional supplements (which may be from plant, animal, or mineral sources) recommended to me by my practitioner are generally safe in the traditionally recommended doses. Possible side effects of herbs include nausea,
gas, stomach ache, diarrhea, and headache. Unusual side effects of plant herbs include vomiting, rashes, hives, and tingling of the tongue. I understand I must stop taking any herbs and notify my acupuncturist if I experience any discomfort or adverse reaction.

I understand that I have the right to refuse any part of the treatment. However I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments. I intend this form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment with Sanctuary Community Acupuncture Clinic.

I will notify my acupuncturist should I become pregnant or if I am in the process of trying to get pregnant as certain acupuncture points and herbs may be contraindicated during pregnancy.

Patient printed name: _____

Patient signature X_____Date_____