

# Acupuncture Alternative Care

## CONSENT TO TREATMENT

I, \_\_\_\_\_, voluntarily consent to receive Acupuncture and/or Chinese Herbal Medicine treatment.

I understand that the evaluation given me is an energetic assessment of the functioning of any organs and the Acupuncture Meridian Network; it in no way purports to be, or replaces allopathic (western) medical evaluation, diagnosis, or treatment.

I understand that no guarantee has been made concerning the use and effects of Acupuncture and Chinese Herbal Medicine.

I understand that I may stop treatments at any time.

I understand that Acupuncture is the insertion of fine sterile needles, with or without the addition of stimulation, through the skin, and/or the application of heat to improve blood circulation, organ function and improve health.

I acknowledge that, although rare, certain side effects may result from Acupuncture, heat therapy and Chinese Herbal Medicine. These may include minor bruising, minor bleeding or some pain at the site of needle insertion. Side effects of Chinese Herbal Medicines are rare but may include allergic reactions.

I am choosing Acupuncture and/or Chinese Herbal Medicine treatment as an exercise of my right to freedom of choice in the healing arts.

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\_\_\_\_\_  
**Signature of Patient** **Date**

**CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION  
FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS**

**NAME** \_\_\_\_\_  
**BIRTHDATE** \_\_\_\_\_ **DATE** \_\_\_\_\_

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

**I understand that this information serves as:**

A basis for planning my care and treatment.

A means of communication among the many healthcare professionals who contribute to my care.

A source of information for applying my diagnosis and surgical information to my bill.

A means by which a third-party payer can verify that services billed were actually provided.

A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

**I understand that I have the right:**

To object to the use of my health information for directory purposes.

To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.

To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

**I request the following restrictions to the use of disclosure of my health information:**

**Patient:**

**X** \_\_\_\_\_

**Patient Signature or Legal Representative      Date**

## OUR PRIVACY POLICY

Dear Valued Patient,

**This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.**

**In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.**

*Safeguards in place at our office include:*

limited access to facilities where information is stored;

policies and procedures for handling information;

requirements for third parties to contractually comply with privacy laws; and

all medical files and records are kept on permanent file.

*Types of information that we gather and use:*

**In administering your health care, we gather and maintain information that may include non-public personal information.**

About your financial transactions with us (billing transactions).

From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.

From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (e.g. requests for medical records, claim payment information).

**In certain states, you may be able to access and correct personal information we have collected about you.**

**We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at 617.776.2020.**

Sincerely,

Patricia Crawford, M. Ac, L. Ac  
Acupuncture Alternative Care