Acupuncture and Wellness of Charleston, LLC
Mailing address: 164 Market Street, #302, Charleston, SC 29401
acupunctureandwellness@yahoo.com, 843-513-7477

ACUPUNCTURE INFORMED CONSENT TO TREAT

*I understand that in the State of South Carolina, "acupuncture" means a form of health care developed from traditional and modern oriental concepts for health care that employs oriental medical techniques, treatment, and adjunctive therapies for the promotion, maintenance and restoration of health and the prevention of disease. I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below.
*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 a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs or any part of my treatment. I recognize the potential risks and benefits of these procedures as described. I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, dizziness or fainting, discomfort, pain or blistering at the site of the procedure, temporary discoloration of the skin, nausea, loose bowel movements, abdominal cramping, and aggravation of symptoms existing prior to the acupuncture treatment. Bruising is a common side effect of cupping. Unusual risks of acupuncture may include spontaneous miscarriage. I will notify my practitioner immediately if I am pregnant or become pregnant. Other unusual risks include nerve damage and organ puncture including lung puncture (pneumothorax). Infections are another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements that may be 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. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, diarrhea, rashes, hives, and tingling of the tongue.
I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks, at the time and based upon the facts then known, is in my best interest. I understand that results are not guaranteed.
*I understand that my practitioner may recommend, at any time, that I seek a medical diagnosis and/or treatment from a licensed medical doctor or dentist if she feels that this is in my best interest. I also understand that a visit to a licensed medical doctor or dentist may be recommended if I have not experienced clinical improvement after three consecutive months of treatment for a specific complaint.
***Notice to cancer, epilepsy, and "acquired immune deficiency syndrome" patients:** I understand that if I have cancer, epilepsy or AIDS, I must be under the care of a medical doctor and that I must be following a treatment program prescribed by a medical doctor for these conditions.
***Notice to Pregnant Women**: Labor-stimulating acupuncture points are not used unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment. All female patients must alert the practitioner/acupuncturist if they know or suspect they are pregnant.
***Potential benefits of this type of treatment**: drugless relief of presenting symptoms and improved balance of bodily energies, which may lead to prevention or elimination of the presenting problem and the strengthening of the constitution.
***Potential risks of not having this type of treatment**: condition may worsen or not improve.
***Alternatives to this type of treatment**: traditional/conventional treatment is also available from other practitioners.
*I understand that the clinical staff and administrative staff may review my patient records and lab reports, but all my records will be kept confidential. I understand that a record will be kept of the health services provided to me. I understand that my medical record will be kept for a minimum of ten, but no more than thirteen years after the date of my last treatment. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my practitioner to the best of his/her ability. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Catherine Jones, ND, MS, LAc regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.
*By voluntarily signing below, I show 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 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.

_____	_____
Guardian/Personal Representative's Name (PRINT)	Patient's Name (PRINT)
_____	_____
Guardian/Personal Representative's Signature	Patient's Signature
_____	_____
Relationship/Representative's Authority / Date	Date
_____	
Acupuncturist: Catherine Jones, ND, MS, LAc	Chief complaint: _____

Patient Information

Last Name: _____ First Name: _____ Middle Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

SS#: _____ Home Ph:(_____)_____ Work Ph:(_____)_____ Cell Ph:(_____)_____

May we leave confidential voice-mail messages for you at any of the above numbers? ❍ No ❍ Yes (specify): ❍ **Home** ❍ **Work** ❍ **Cell**

Date of Birth: _____ Sex:_____ Other names that records may be kept under: _____

Are you a student at another university or college? Y N What is your current status? FT PT Are you currently employed? Y N

Employer/School: _____

Mother's Name (minors only): _____ Father's Name (minors only): _____

Emergency Contact: _____ Relationship to Emergency Contact: _____

Contact's Phone #1: (_____)_____ ❍ Home ❍ Work ❍ Cell Do you have special needs?: ❍ No ❍ Yes (see front desk)

How did you hear about us? ❍ Newspaper Ad ❍ News Story ❍ Mailer/Flyer ❍ Website ❍ Workshop/Event ❍ Medical Referral ❍ Friend/Family ❍ Yellow Pages ❍ T.V. Ad ❍ Insurance Co. ❍ Other: _____

The following information is requested for our grant and federal reporting requirements and is optional

Marital Status *(circle one):* Single/Never Married Married Divorced Separated/Not Divorced Widowed Domestic Partnership Other

Race/Ethnic Origin: African/African-American Asian Caucasian Native American Pacific Islander/ Native Hawaiian Mixed Race Other

Number of members in your household: _____ **Gross annual household income:** _____ /year

Guarantor Information

This section must be completed if someone other than the patient is financially responsible for the patient's account.

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: (_____)_____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below.

X _____ _____

Guarantor's Signature **Date**

Terms of Agreement

Financial Terms: I understand that payment is due at the time of each visit. I understand that any guarantor listed above is subject to the same financial terms as outlined in this paragraph and that my payment history, account balance and due dates may be disclosed to the guarantor for the purposes of securing payment. I understand that the guarantor, if someone other than myself, is not authorized to receive my medical information unless expressly authorized by me in writing.

Privacy terms: Acupuncture and Wellness of Charleston, LLC is required to provide you with a copy of its Notice of Privacy Practices and to obtain written acknowledgement, if possible, that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information at our clinic, wish to inquire about your rights or if you wish to schedule an appointment to view your medical record, please contact Catherine Jones, ND, MSA, LAc.

I hereby acknowledge that I have received a copy of Acupuncture and Wellness of Charleston, LLC's Notice of Privacy Practices.

X _____ _____

Patient's Signature Date

X _____ _____

Guardian/Representative's Signature Date

_____

Relationship to Patient/Representative Authority

OFFICE USE ONLY

Unable to Obtain Acknowledgement

This section serves as a record of the above practitioner's good faith effort to obtain written acknowledgement of receipt from the patient for the Notice of Privacy Practices. Patient was given a copy of the notice on: _____.

- ❍ Patient refused to sign acknowledgement.
- ❍ Patient is physically unable to sign acknowledgement.
- ❍ Other: _____

DATE _____

PATIENT PROFILE

Last Name: _____ First Name: _____

Nickname: _____ Birthdate:_____ Sex: _____

A note to our patients: Please complete this two-sided questionnaire as thoroughly as possible in order to aid your clinicians in their diagnosis and treatment. This is a confidential record of your medical treatment and will not be released, except when you have provided us with written authorization to do so. Thank you.

PRESENT HEALTH CONCERNS

Please list most important health concerns in their order of significance.	Prior diagnosis of this problem? If so, what?	Indicate painful or distressed areas: Draw or list
1.		
2.		
3.		
4.		
5.		

What goals do you have for your visit at the clinic today? _____

_____

Have you ever consulted a Naturopathic physician, an Acupuncturist, a Nutritionist or a Counselor before? (please circle)

Do you have any questions about our clinic or the care that you've chosen today? _____

_____

Please list prescription medications that you are currently taking, with dosages:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

List vitamins, minerals, herbs, homeopathic remedies that you are currently taking, with dosages:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Please list any allergies to medications, foods, etc:_____

Explain: _____

Personal Habits:

Please circle any of the following substances that you use regularly: Tobacco Coffee/black tea/cola

Alcohol Recreational drugs

Do you follow any particular diet regimens or restrictions? If yes, please describe: _____

_____

Do you exercise regularly? ❑Yes ❑No What type?

How long? _____ How often?

Past History:

Hospitalizations: _____

_____

Serious Illnesses and Injuries:_____

_____

Date of last physical/annual exam_____ Date of last blood tests:

Personal and Family History:

Please check the "yes" box next to each condition that applies to you or one of your family members. Please note whether condition applied to family member in the past or currently by denoting a "P" for past or "C" for current. Indicate the relationship or the word "self" in the "Relationship" column.

	YES	RELATION	DATES RESOLVED Past(P)/Current(C)		YES	RELATION	DATES RESOLVED Past(P)/Current(C)
Alcoholism/Drug Addiction				Headaches			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				High Blood			

				Pressure			
Asthma				Kidney Disease			
Cancer				Mental Illness			
Depression				Stroke			
Diabetes				Tuberculosis			
Eczema				Other			
Epilepsy							

Social History:

Please circle those that apply: Single Married Separated Divorced Widowed Other

Do you have any children? Yes No Please list their age(s) _____

Notice of Privacy Practices
Acupuncture and Wellness of Charleston, LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have questions concerning this notice, please contact your practitioner.

Catherine Jones, ND, MS, LAc
Mailing address: 164 Market Street, #302, Charleston, SC 29401
acupunctureandwellness@yahoo.com
Phone: 843-513-7477

We respect your privacy and understand that your medical information is personal and sensitive. Moreover, we are required by law to make sure that medical information that identifies you is kept private. This *Notice of Privacy Practices* describes how we may use or disclose your protected health information at our clinic. We are required to give you this notice of our legal duties and abide by the terms of this notice; however, we may change our notice at any time. **Please note that any new notice adopted will be effective for all protected health information maintained at the time of change.** You will not be notified individually if a change is made to our notice, however, upon request, we will provide you with a copy of our current notice. You may always obtain a copy of our current notice by any of the following means:

1. Contacting our office by mail or by phone at the above address and phone number
2. Asking for a copy at the time of your next visit.

SECTION 1: We use and disclose your protected health information to carry out your treatment, obtain payment and conduct health care operations.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes disclosures to other third parties that are involved in your health care elsewhere. Specifically, we would disclose your protected health information to other physicians who may be treating you when we have the necessary permission from you to do so. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may occasionally disclose your protected health information to another physician or health care provider, such as a medical specialist or laboratory, who becomes involved in your care by providing assistance with your health care diagnosis or treatment.

(Not Applicable for this clinic)Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for coverage of future treatment with some medical modalities may require that your relevant medical information be disclosed to the health plan to obtain approval for future scheduling. Similarly, insurance companies may require that copies of your applicable medical records accompany any requests for payment of services already provided to you.

Healthcare Operations: We may use or disclose, as necessary, your protected health information in order to support various business activities of our clinic. These activities include, but are not limited to, quality assessment activities, employee reviews, licensing, marketing and fundraising activities, and conducting or arranging for similar business activities.

For example, we may call you by name in the waiting room when ready to see you, and we may use or disclose your protected health information, as necessary, to contact you and remind you of your upcoming appointment(s).

We will share your protected health information with third party business associates that perform various activities—such as billing, collections, or records management—for the clinic. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our clinic and the services we offer. We may also send you information about products or services that we believe may be beneficial to you.

SECTION 2: Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

Per Your Authorization: If you give us authorization to use or disclose your protected health information, you may revoke such authorizations at any time, in writing, except to the extent that our clinic has already taken action in reliance on the use or disclosure permitted in the authorization.

Legally Permitted/Opportunity to Object: We may use and disclose your protected health information in the following instances, but you will be given the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of such information, then we may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

1. To Others Involved in Your Healthcare: Unless you object, we may disclose your protected health information to a member of your family, a relative, a close friend or any other person you identify, to the extent the information directly relates to that person's involvement in your health care. For example, we may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. In Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your practitioner or physician shall try to obtain your consent as soon as reasonably possible after the delivery of treatment. If your practitioner or physician or another practitioner or physician in the practice must treat you and the practitioner or physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

3. With Communication Barriers: We may use and disclose your protected health information if your practitioner or physician or another practitioner or physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances and the use or disclosure is done in accordance with other applicable laws.

Legally Permitted/No Opportunity to Object: We may use or disclose your protected health information in the following situations without your consent or authorization:

1. When Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the applicable law(s) and will be limited to the relevant requirements of the law. You will be notified of any such uses or disclosures only if required by law.

2. For Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority. We may also disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

3. For Health Oversight/Compliance Monitoring: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

4. Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, if we believe that you have been a victim of abuse, neglect or domestic violence, we may disclose your protected health information to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

5. To the FDA: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

6. Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal, in certain conditions in response to a subpoena, discovery request or other lawful process.

7. Law Enforcement: We may disclose protected health information for law enforcement purposes, so long as applicable legal requirements are met. Such purposes generally include: 1) those required by law; 2) limited information requests for identification and location purposes; 3) those pertaining to victims of a crime; 4) suspicion that death has occurred as a result of criminal conduct; 5) those where a crime occurs on the premises of the practice; and 6) medical emergencies where it is likely that a crime has occurred.

8. Research: We may disclose your protected health information to researchers when an institutional review board has approved their research. The institutional review board will have reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

9. Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel to authorized authorities; such as for determinations of your eligibility for benefits. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President, foreign heads of state or others legally authorized.

10. Workers' Compensation: We may disclose your protected health information to comply with workers' compensation laws and other similar legally established programs.

11. Coroners, Funeral Directors, and Organ Donation: We may disclose your medical information to a coroner, medical examiner or funeral director, if necessary, for them to carry out their duties should you die.

12. Inmates: We may disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of a correctional facility or under the custody of a law enforcement official and your physician created or received your protected health information in the course of providing care to you. Such information may be released only for the following purposes: 1) to enable the correctional institution or law enforcement official to provide you with necessary healthcare services; 2) to protect your own health and safety or the safety of others; and 3) for the safety and security of the correctional institution.

SECTION 3: Specially-Protected Information

Special laws may restrict the use and disclosure of medical information related to mental health conditions, substance abuse, sexually transmitted diseases and HIV/AIDS. For example, we generally do not disclose specially protected information in response to a subpoena or other compulsory process unless: 1) you provide written authorization; or 2) a court orders the disclosure and mandates the necessary safeguards to protect the information after it is released.

SECTION 4: Your Rights

The following is a list of your rights with respect to your protected health information and a brief description of how you may exercise those rights. Should you have questions about this section or if you wish to exercise your rights, please contact Catherine Jones ND, MS, LAc at the number listed on page one.

The right to inspect and obtain a copy of your protected health information. This means you may inspect and obtain a copy of the protected health information we maintain about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the institution use for making decisions about you. We may deny you access to some records as state and federal laws permit, however, if you are denied access, you may request a review or designate a health care provider with equal qualifications to receive the information instead.

The right to request a restriction on the use or disclosure of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations as described in Section 1 of this notice. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes. Your request must be in writing and state the specific restriction requested and to whom or in what situation you want the restriction to apply. Please note that we are not required to agree to a restriction that you may request. If we believe it to be in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. However, if we agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with Catherine Jones, ND, MS, LAc.

The right to request that you receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request.

The right to request an amendment/correction to your health record. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request, you have the right to file a statement of disagreement with us, and the statement of disagreement you provide will be released along with the information challenged whenever it is released. We may also include a letter of rebuttal, which will also be released along with the challenged information. You are entitled to a copy of any letter of rebuttal we may place in your record.

The right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this *Notice of Privacy Practices*. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after November 1, 2006. The right to receive this information is subject to certain exceptions, restrictions and limitations.

The right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

SECTION 5: Complaints, Comments and Inquiries

If you believe your privacy rights have been violated, you may report the suspected violation to us by contacting our clinic at 843-513-7477 or by contacting the Secretary of Health and Human Services. We will take no punitive action against you for filing a complaint.

This notice becomes effective on **November 1, 2006.**