Harmonic Healing Acupuncture

Patient Information

Last Name: _____ **First Name:** _____ **MI:** ____
Date of Birth: _____ **Age:** _____ **Email:** _____
Social Security #: _____ **Employer:** _____ **Occupation:** _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
What phone number is the best to contact you? _____
Emergency Contact: _____ **Relationship:** _____
Emergency Contact Phone: _____
Insurance: _____ **Member#:** _____ **Group #:** _____
Acupuncture coverage: _____
Who referred you? _____

Office Policies

Please read and initial to indicate your understanding of our policies

Insurance:
Your policy is a contract between you and your insurance carrier. It is your responsibility to read it, understand it, and to know what it covers and what it does not. Do not assume your policy automatically covers acupuncture. If your insurance requires a referral from your primary care physician, it is your responsibility to make sure you can obtain one and that it is on file with your insurance company. As a courtesy to you I will bill your insurance company, but if for any reason your claim is denied, or only partially covered, you will be financially responsible for all charges incurred. **Initial** _____

Payment Policy:
We accept Credit/Debit, check, and cash. Monthly payments are required on outstanding balances. If you are a new patient with no insurance or an insurance company that we do not bill or that does not cover our services, you will be required to pay in full at the time of service. **Initial** _____

Co-pays:
If we are billing your insurance, all co-pays and co-insurance will be collected at the time of service.
Initial _____

Late Fees:
A late fee in the amount of 10.00 or 10% of your balance will be applied to an unpaid balance that is 60 days overdue. These fees will continue to accrue until the balance has been paid. **Initial** _____

NSF Checks:
If a check is returned NSF, there will be a $25.00 NSF charge applied to your account in addition to the amount of the original check. **Initial** _____

Missed appointments:
Please cancel your appointment within 4 hours of your appointment time. Repeat cancellations may result in a 25.00 cancellation feel. Failure to show up to your appointment without calling to cancel will result in a 50.00 charge for the reserved appointment time. If you are late for an appointment, your treatment time will be cut short the amount of time you are late so that we may remain on schedule for the day. **Initial** _____

I have read the preceding information and understand that I am financially responsible for all charges and I agree to pay for these services rendered.

Patient Signature_____ **Date**_____

Harmonic Healing Acupuncture
Michelle L Wilson, EAMP
1551 NW 54th Street, Suite 204
Seattle, WA 98107

Consent for Treatment

I hereby authorize Michelle Wilson, McKenzie Myers to perform the following specific procedures as necessary to facilitate my treatment:
Acupuncture: insertion of special sterilized needles through the skin into underlying tissues at specific points on the body.
Cupping: a technique to relieve symptoms in which cups made of glass or other materials are placed on the skin with a vacuum created by heat or other device.
GuaSha: a rubbing on an area of the body with a blunt round instrument.
Moxibustion: indirect or direct burning of herbs on an acupoints or area using a stick, cone, or ball moxa to relieve symptoms.
Herbal medicines: Chinese herbal patents or western herbal formulas (including plant, animal, and/or mineral materials). These medicines may be given in the form of teas, tinctures, pills, topical creams, pastes, plasters, and other forms.
Tuina: an ancient localized massage used to treat a wide variety of common disharmonies.
Electro-therapy: the application of electric stimulation between points.
Thermal therapies: infrared and heat therapies.
Dietary Advice: based on traditional Chinese Medical Theory.
Acutonics: the use of tuning forks on or around acupoints or over the body.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects. I recognize the potential risks, side effects, and benefits of these procedures as described below:

Potential risks: bruising, numbness or tingling near the needling sites that may last a few days, discomfort, pain, infection, or blistering at the site of the procedure; temporary discoloration of the skin; and dizziness or fainting. Bruising is a common side effect of cupping. **Unusual** risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although this clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. 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 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. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

I do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the practitioner to exercise judgment during the course of treatment which the practitioner thinks at the time, based upon the facts then known is my best interest. I understand that results are not guaranteed.

Potential benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to pregnant women: All female patients must alert the practitioner if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been informed 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. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law.

_____ _____
Patient's Name (or representative) PRINT Patient's Signature Date

Harmonic Healing Acupuncture
Michelle Wilson, EAMP

Consent for Purposes of Treatment, Payment and Health Care Operation

I consent to the use or disclosure of my identifiable health information by Michelle Wilson, McKenzie Myers for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me at *Harmonic Healing Acupuncture* may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my identifiable health information is used or disclosed, and to carry out treatment, payment, or health care operations of the practice.

I have the right to revoke this consent, in writing, at any time except to the extent that *Harmonic Healing Acupuncture* has taken action in reliance on this consent.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer, or a health care clearinghouse. This identifiable health information relates to my past, present, or future physical or mental health or condition, and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that as part of my healthcare, this *Harmonic Healing Acupuncture* 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 I have the right to review and request a copy of *Harmonic Healing Acupuncture*'s Notice of Privacy Practices prior to signing this document. By signing this document I am approve of these Privacy Practices, and uses of my identifiable health information.

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 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.

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

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_____ _____
Signature of Patient or Authorized Representative/relationship Date