POINT TO HEALTH ACUPUNCTURE

INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the 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, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, gua sha, Chinese herbal medicine, nutritional counseling, electrical stimulation, AMMA massage therapy, Tui-Na (Chinese massage), and Zero Balancing©. 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.

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, and dizziness or fainting. Bruising is a common side effect of cupping and gua sha. If moxibustion or heat therapies are used there is a potential risk of burn and/or scarring. Rare risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) 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 will notify a clinical staff member who is caring for me if I am or become pregnant.

I understand that there is no guarantee or warranty for any specific result of the care I receive at Point to Health Acupuncture. I recognize that, as in all types of medicine, the response to therapy varies with each patient.

Therapies and advice offered shall not be construed by the client to be a diagnosis of treatment of any disease or injury.

Acupuncturists in New York are not licensed to prescribe pharmaceutical drugs. If you want the clinic to treat a condition that is currently medicated we will do so as long as the condition has been diagnosed by your doctor and is not an emergency condition. If the patient decides to alter their pharmaceutical regime in any way the patient must consult their doctor before doing so.

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. I, hereby release Point to Health Acupuncture / Lauren Glauberg, M.S., L.Ac. from any and all liability that may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care.

NAME OF ACPUNCTURIST: Lauren Glauberg, M.S., L.Ac.

PRINTED NAME:_____ DATE: _____

PATIENT SIGNATURE:_____
(Or Patient Representative) (Indicate relationship if signing for patient)

PATIENT ADVISORY TO CONSULT A PHYSICIAN

All patients are advised under New York State Law (Article 160, Section 8211.1 (b)) to consult a physician regarding the condition or conditions for which they are seeking acupuncture treatment. In addition, patients are responsible for seeking the advice and treatment of a physician should their symptoms change for the worse, or should a new condition arise.

I, THE UNDERSIGNED, DO AFFIRM THAT THE UNDERSIGNED PATIENT HAS BEEN ADVISED BY, LAUREN GLAUBERG, M.S., L.AC., TO CONSULT A PHYSICIAN REGARDING THE CONDITION OR CONDITIONS FOR WHICH SUCH PATIENT SEEKS ACUPUNCTURE TREATMENT.

I have read and agreed to the Assignment of Benefits, Notice of HIPAA Privacy Practice, and Advice under New York State Law described above.

PATIENT SIGNATURE:_____ DATE: _____
(Or Patient Representative - Indicate relationship if signing for patient)

PRACTITIONER SIGNATURE:_____ DATE: _____

POINT TO HEALTH ACUPUNCTURE

OFFICE POLICIES & PROCEDURES

CANCELLATION & LATENESS POLICIES

If you need to cancel your appointment, please do so by **3:00pm** the day prior to the appointment. If an appointment is missed, canceled or changed **after 3:00pm**, the usual rate for the session will be charged.

Appointment times have been reserved exclusively for you. If you arrive **less than 30 minutes late**, your session may be shortened in order to accommodate patients whose appointments directly follow your session. Regardless of the length of the treatment, you will be responsible for the rate of the full session.

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If you arrive **more than 30 minutes late** you will be charged the rate of the full session may be asked to forfeit your session.

Point to Health Acupuncture understands there are times when cancellations may be necessary on short notice and reserves the right to waive fees under certain circumstances such as emergencies and acts of nature.

The cancellation and no show fees are the sole responsibility of the patient and must be paid in full before the next appointment.

FEE SCHEDULE

Initial Visit **$150**
New Patient Intake & Assessment + Full Treatment/Approximately 90 minutes

Follow Up Visit **$120**
Full Treatment/Approximately 60 minutes

ACCEPTABLE METHODS OF PAYMENT

Fees due and payable in full at the time of your office visit. Cash, check or credit card is accepted. There will be a $30 fee for all returned checks.

INSURANCE COVERAGE

Many insurance policies cover acupuncture care, but Point to Health Acupuncture makes no representation that your insurance company offers acupuncture benefits. I authorize my insurance benefits be directly paid to Point to Health Acupuncture. If my insurance carrier sends payment to me for services incurred in this office, I agree to send or bring those payments to the Point to Health Acupuncture office upon receipt. The balance of my claim is my responsibility whether or not my insurance company pays my claim. I authorize Point to Health Acupuncture or my insurance company to release any information required to process my claims. I agree to pay the reduced fee of $150 for the initial treatment and $120 for each follow-up treatment if my insurance company does not offer acupuncture benefits.

Please indicate your understanding and acceptance of these policies by signing below.

PATIENT SIGNATURE:_____ DATE: _____
(Or Patient Representative - Indicate relationship if signing for patient)

NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act (HIPAA)
Notice of Privacy Practices

This notice describes how health and medical information about you may be used and disclosed and how you can get access to this information.

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

CONSENT

Point to Health Acupuncture may use and/or disclose your PHI with a written Consent from you for the purposes of:

- **Treatment**: In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. Your PHI may be shared in the form of written or electronic records or spoken words, and my include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

- **Payment**: In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payors, pursuant to their billing and payment requirements.

- **Health Care Operations**: In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI.

CONSENT NOT REQUIRED

The Practice may use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

a) **De-identified Information**: Information that does not identify you and, even without your name, cannot be used to identify you.
b) **Business Associate**: To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.
c) **Personal Representative**: To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.
d) **Emergency Situations**:
    i. for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or
    ii. to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.
e) **Communication Barriers**: If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

f) **Public Health Activities**: Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.
g) **Abuse, Neglect or Domestic Violence**: To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.
h) **Health Oversight Activities**: Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.
i) **Judicial and Administrative Proceeding**: For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.
j) **Law Enforcement Purposes**: In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.
k) **Coroner or Medical Examiner**: The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.
l) **Organ, Eye or Tissue Donation**: If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.
m) **Research**: If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.
n) **Avert a Threat to Health or Safety**: The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.
o) **Workers' Compensation**: If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

APPOINTMENT REMINDERS

- The Practice may contact you to provide appointment reminders, information about your treatment, treatment alternatives and/or other health-related information via phone or email. If you are not at home to receive an appointment reminder, a message will be left on your answering machine, voice mail or with the person who answers the call.
- You have the right to refuse us authorization to contact you to provide appointment reminders. If you refuse us authorization, it will not affect the treatment we provide to you.

FAMILY/FRIENDS

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care unless you direct the Practice to the contrary. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure.
b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

YOUR RIGHTS

1. You have the right to:
    a) **Revoke any Authorization and/or Consent, in writing, at any time**. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

b) **Request restrictions on certain use and/or disclosure of your PHI as provided by law**. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

c) **Receive confidential communications or PHI by alternative means or at alternative locations**. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

d) **Inspect and copy your PHI as provided by law**. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice.

e) **Amend your PHI as provided by s provided by the law**. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

f) **Receive an accounting of disclosures of your PHI as provided by the law**. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The Practice may charge you a fee for the cost of copying, mailing or other supplies associated with your request.

g) **Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer**.

h) **File a complaint with the Practice or to the Secretary of HHS if you believe your privacy rights have been violated**. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

PRACTICE'S REQUIREMENTS

1. The Practice:
    a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
    b) Is required by state law to maintain a higher level of confidentiality with respect to certain portions of your medical information that is provided under federal law.
    c) Is required to abide by the terms of this Privacy Notice.
    d) Reserves the right to change the terms of this Privacy Notice and make the new Privacy Notice provisions effective for all of your PHI that it maintains.
    e) Will distribute any revised Privacy Notice to you prior to implementation.
    f) Will not retaliate against you for filing a complaint.

By signing below, I acknowledge that I have read and understand the Notice of Privacy Practices and have therefore been advised of how medical information may be used and disclosed in the office, and have also been informed of how I may gain access to and control this medical information.

PATIENT SIGNATURE:_____ DATE: _____
(Or Patient Representative - Indicate relationship if signing for patient)