Sherwood Acupuncture, LLC
20510 SW Roy Rogers Rd, Ste 100
Sherwood, OR 97140-0001

Consent to Treatment, Office Policies, and Privacy

Welcome Sherwood Acupuncture! We look forward to addressing all of your health needs. We encourage your questions and participation in all aspects of your health care. Please make sure to read through this document in its entirety, mark each box appropriately, and insert your signature at the bottom.

INFORMED CONSENT FOR ACUPUNCTURE AND ORIENTAL MEDICINE

I hereby voluntarily consent to receive Naturopathic medical treatments and or Acupuncture and Oriental medicine treatment for my present and future health condition. I understand treatment will be administered by Amy Brose Mendenhall, L.AC., Andrea Clow, L.AC, Dana Lockhart ND, L.AC., Sydney Hwang ND, L.AC., or Lori Forest ND. The treatments that will possibly be administered are described below: *

☐ I agree

ACUPUNCTURE:

Acupuncture is performed by the insertion of very thin sterile disposable needles through the skin at various locations on the body. This is done in an attempt to treat bodily dysfunction or disease, to modify or prevent pain perception, and/or to normalize the body's physiological functions. I am aware of certain potential side effects. These include, but are not limited to: mild but temporary discomfort at the acupuncture site, occasional slight bleeding, occasional local bruising, dizziness or fainting, or possible aggravation of symptoms existing prior to acupuncture treatment. Extremely rare risks of acupuncture include nerve damage, organ puncture or infection. I understand that I am free to stop acupuncture treatment at any time. *

☐ I understand

CHINESE HERBS:

Substances from the Oriental materia medica may be recommended to treat bodily dysfunction or diseases or to modify or prevent pain perception and to normalize the body's physiological functions. These may be given orally or topically (on the skin). Patients must follow the directions for administration and

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dosage. Chinese herbs generally have few side effects, but there may be certain adverse effects such as: changes in bowel movements, abdominal pain and/or discomfort, skin reaction/hives, allergic reaction or possible aggravation of symptoms existing prior to treatment. Should I experience any problems which I associate with these substances, I should stop using them and call Sherwood Acupuncture, LLC as soon as possible. *

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ACUPRESSURE/MASSAGE:
Acupressure or massage is used to modify or prevent pain perception and to normalize the body's physiological functions. Possible side effects include: muscle soreness or achiness and possible aggravation of symptoms existing prior to the treatment. I understand that I am free to stop treatment at any time. *

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LASER TENS THERAPY:
A small handheld laser TENS (electro) treatment device may be used. This device is rubbed across acupuncture points using a gel in an effort to treat pain and inflammation in the underlying tissues. Usually patients feel a light tingling on the skin from the electro (TENS) on the tip of the device. Possible side effects include: tingling or skin irritation while the device is used, possible aggravation of symptoms existing prior to the treatment. I understand that I am free to stop treatment at any time. *

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ELECTRO-ACUPUNCTURE (TENS):
A mild electro micro-current may be used to stimulate the acupuncture points. Cords from the machine are connected to specific acupuncture points in an effort to modify or prevent pain perception. A mild tingling or tapping sensation will be felt. Possible adverse side effects include: electrical shock, pain or discomfort, or the possible aggravation of symptoms existing prior to treatment. I understand that I am free to stop electro-acupuncture treatment at any time. *

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HEAT TREATMENT:
A heat lamp (TDP lamp) may be used to warm areas

of the body in an effort to relax muscles and reduce pain. The rare possibility of mild burns exists. I understand that I am free to stop heat treatment at any time. *

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GUA SHA:

Gua sha is a technique using plastic or ceramic tools. The tools are scraped along the skin in an effort to 'move blood' to treat pain, cold or flu. Gua sha can leave some marks or bruises (resembling 'road rash')in the area where the scraping is performed . It could possibly leave the area feeling sore. I understand that I am free to stop gua sha treatment at any time. *

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CUPPING:

Cupping uses glass or plastic round 'cups' that act as suction devices. They are placed on the skin to bring blood to the surface and improve circulation to the area. This technique will leave round bruise marks in the area that are usually not painful. I understand that I am free to stop cupping at any time. *

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I understand that I am free to request more information at any time if desired.

I consent to treatment with acupuncture and Oriental Medicine at Sherwood Acupuncture, LLC.

I understand there are no guarantees concerning treatment. I understand there may be other treatment alternatives, including treatment by a licensed physician.

I understand that I have the right to refuse or discontinue treatment at any time. *

OFFICE POLICES

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PATIENTS WITH INSURANCE:

We bill insurance as a courtesy to our patients. The relationship between 'insurance company' and the 'insured' is exactly that. It is a relationship between the insurance provider and the patient. This clinic is a third party who is billing for payment on your behalf. You are responsible for knowing your acupuncture benefit and reimbursement. We will do everything we can to make insurance billing a smooth process, but billing insurance is not a guarantee of insurance

payment. You will be responsible for all charges not paid by insurance, with few exceptions.

All co-payments are due at the time of service. Deductibles are due at the time of service.

I understand that I am responsible for any amount not covered by my insurance. * ☐ I understand

PATIENTS WITHOUT INSURANCE:

A 'time of service' discount applies when a patient pays for their visit in full on the same day as treatment is provided. Please see posted fee schedule for time of discount fees. This discount cannot be offered if payment is made on a day other than the day of treatment. Please let our office know if you are having financial difficulty and need to discuss sliding scale or payment plans. * ☐ I understand

A $30 per item fee will be billed to patients for NSF checks. *

May we leave messages at your given phone numbers? * ☐ Yes ☐ No

May we leave messages with others who answer your phone? * ☐ Yes ☐ No

MISSED APPOINTMENTS: ☐ I understand

There is a $25 charge for missed appointments. Please call our office as soon as possible if you think you may miss your appointment, as other patients may want your appointment time. Your time is reserved especially for you. Please respect other patients and this clinic by letting us know if you are having a problem getting to your appointment.

NOTICE OF PATIENT PRIVACY PRACTICES (HIPAA)

☐ I understand

This notice describes how your medical information may be used and disclosed and how you may gain access to this information. Sherwood Acupuncture, LLC will ask you to sing an Acknowledgement that you have received this Notice of our Patient Privacy Practices, In accordance with HIPAA Privacy

Regulation, this notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. The notice also describes your rights and Sherwood Acupuncture, LLC's requirements to protect your health information.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS:

For purposed of treatment - We will use your health care information to treat you. For example, we will use your information to help us diagnose and design a course of treatment for you. Your treatment may include acupuncture, massage and herbs. We may also, for the purpose of treatment, disclose your PHI to another health care provider when need by the provider to render treatment to you.
For payment service- We will use your health care information to receive payment for services and products. We will bill you and/or a third party payor for the cost of treatments and herbs provided to you. The information on or accompanying your bill may include your identification, as well as the herbs you are taking.
For health care operations- We may use and disclose your PHI for all activities that are included within the definition of "health care operations" as defined in the federal privacy regulations.
OTHER USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION PERMITTED OR REQUIRED BY REGULATION:

Friends and Family- We may disclose your PHI to friends and family in case of an emergency to the extent necessary to help with your health care or with payment of your health care . Using their judgement as health care professionals, our acupuncture staff may disclose PHI with a family member, other relative, close personal friend, or any person you identify as being involved in your health care.

Reminder Calls - We may contact you to provide reminders of herbal refills or appointments or other health related services that may be of interest to you.

Other Covered Entities - We may disclose PHI to another covered entity to conduct health care operations in the area of quality assurance activities.

Disclosure to the U.S. Department of Health and Human Services - When the U.S. Department of Health and Human Services is investigating or determining our compliance with the federal privacy regualtions, we are required to disclose your PHI to DHHS.

Abuse or Neglect - We may disclose you PHI to appropriate authorities if we believe you may be a possible victim of abuse, domestic violence, neglect, or other crimes.

Serious Threat to Health or Safety- We may disclose your PHI if we believe that the disclosure id necessary to prevent a serious threat to your health or safety or the health and safety of the public or another person.

Public Health and Safety - We may release your PHI to public health or legal authorities charged with preventing or controlling disease, injury or disability, For example, we may release PHI to the Food and Drug Administration relative to adverse events regarding drugs, food, supplements and other health products or to post marketing surveillance to enable product recalls or replacements.

Law Enforcement - We may disclose to law enforcement agencies in response to a court order, subpoena, discovery request, administrative order or other lawful processes by another person involved in a dispute involving a patient, but only if efforts have been made to tell the patient about the request or to obtain an order protecting the requested health care information.

Other Required or Permitted Disclosures:

We may disclose your PHI to the following entities under given circumstances:

Whenever is required to do so by law: To a correctional institution or its agents, if patient is or

becomes and inmate of such and institution, when necessary for the patient's health or the health and safety of others. To notify, or assist in notifying a family member, personal representative, or another person responsible for the patient's care, or the patient's location, or general condition. To the military authorities under certain circumstances when the patient is a member of the Armed Forces. To authorized federal officials for intelligence, counterintelligence, and other national security activities. *

Authorized Use and Disclosure

We will obtain your written authorization before using or disclosing your PHI for purposes other than those listed above or otherwise required by law. You may revoke an authorization in writing at any time. Upon receipt of this revocation, we will stop using or disclosing your PHI except to the extent that we have already taken action in reliance on the authorization. *

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Patient Rights

Requests for Restrictions - You have the right to request that we restrict how your PHI is used or disclosed in carrying out treatment, payment, or health care operations. Such requests must be made in writing to Sherwood Acupuncture, LLC. In your request tell us 1) the information of which you want to limit our use and disclosure and 2) how you want to limit our use and/or disclosure of the information. We are not required to agree to the requested restrictions, but if we do, we will abide by our agreement except in an emergency.

Access to PHI - You have the right to look at or obtain a copy of your PHI. You must make a request in writing to Sherwood Acupuncture, LLC to obtain access to your PHI. If you request copies, we may charge you a reasonable fee for copies and postage (if you want them mailed).

We may deny your request to inspect and copy your PHI in certain limited circumstances. If you are denied access to your PHI, a you may request that the denial

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be reviewed.

Accounting of Disclosures - You have the right to receive an accounting of the disclosures we have made on or after April, 14th, 2003, of your PHI. We will provide the date on which we made the disclosure, the name of the person or entity to which we disclosed your PHI, a description of the information we disclosed, the reason for the disclosure, and certain other information.

Amendments to Health Care Information - You may request that we amend your PHI if you feel that it is incomplete or incorrect. Your request must be in writing, and it must explain why the information should be amended. If we did not create the information you want amended or for certain other circumstances, we may deny your request. If we deny your request, we will provide you with a written explanation. If denied, you have the right to file a statement of disagreement with the decision. *

For More Information or to Report a Problem

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If you would like additional information or have questions about our privacy practices, you may contact Sherwood Acupuncture, LLC at (503) 610-1531 or by writing to 20510 SW Roy Rogers Rd Ste 100, Sherood, OR 97140. You may also file a written complaint at this address. If you believe your privacy rights have been violated, you may file a complaint with Sherwood Acupuncture, LLC or with the Department of Heath and Human Services.

We support your right to protect the privacy of your PHI. We will not retaliate in any way if you chose to file a complaint with us or the Department of Health and Human Services. *

Patient Signature : _____

Today's Date _____

Signature of Guardian (if applicable): : _____