CONSENT FOR TREATMENT:
Part of this office's role is to provide me with information to assist me in making informed choices and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose to receive the care. I am voluntarily seeking treatment on my own behalf for medical conditions using Acupuncture and Chinese Herbal Medicine according to principles of Traditional Chinese Medicine. Traditional Chinese Medicine is the principles, methodology, and treatment modalities developed over centuries in East Asia including but not limited to Acupuncture and Chinese Herbal Medicine. I understand that while Houston Acupuncture and Primary Care does provide limited primary care services, I will be under the care of an outside primary care physician or medical specialist for the primary diagnosis and treatment of any medical conditions I may have using allopathic medical guidelines. I understand that the general focus of Houston Acupuncture and Primary Care is for medical diagnosis and treatment utilizing Traditional Chinese Medicine and not to proactively pursue conventional allopathic diagnosis or treatment.

Acupuncture is a treatment modality within Traditional Chinese Medicine which involves inserting fine, filiform needles into the skin to enhance the movement of qi in the meridians for health benefits. I understand that acupuncture is not recognized as a conventional or regulated treatment modality by allopathic or mainstream medicine or the FDA. Acupuncture is not intended to substitute for diagnosis or treatment by conventional allopathic methods or to be used as an alternative to necessary medical care. During any acupuncture treatments I agree to lay still while there are any needles present in me and to notify staff immediately of any unusual sensations. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising, bleeding, infection, numbness or tingling near the needling sites, dizziness, fainting, nerve damage and organ puncture, including lung puncture (pneumothorax). I am voluntarily requesting to receive acupuncture as an alternative treatment or as an additional treatment modality to conventional mainstream and allopathic treatment.

I also agree to treatment using Chinese Herbal Medicine. Chinese Herbal Medicine consists of the use of herbal substances from plant, animal and/or mineral sources for the treatment of conditions based on diagnosis and treatment principles according to Traditional Chinese Medicine. I understand that Chinese Herbal Medicine is not recognized as a conventional or regulated treatment modality by allopathic or mainstream medicine or the FDA. Although some of the herbs prescribed may be toxic in large doses, the herbal substances and dosages recommended by Houston Acupuncture and Primary Care are considered safe according to principles of Traditional Chinese Medicine. Herbal substances and their prescribed dosages will be prescribed based on their known characteristics, therapeutic and toxic profiles within Traditional Chinese Medicine, and not based on modern-day scientific studies. I understand that some herbs may be inappropriate during pregnancy. I will immediately notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will immediately discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue. I understand that the herbs need to be prepared consumed according to the instructions provided orally and/or in writing. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs. I understand that I am receiving Chinese herbal treatment as an alternative treatment or additional treatment modality to conventional mainstream and allopathic treatment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that there are treatment options available for my condition other than Acupuncture and Chinese Herbal Medicine. These options may include, but are not limited to: self-administered care, over-the-counter medications, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

___________ (initial) I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, vitamins, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that I am the decision maker for my health care and am seeking treatment in order to further my own health and for no other reason and do not represent a third party. I hereby request and consent to treatment with Acupuncture and Chinese Herbal Medicine on me (or on the patient named below, for whom I am legally responsible) by Houston Acupuncture and Primary Care.
I understand that Houston Acupuncture and Primary Care does also provide limited allopathic examination, testing and treatment. This will be performed on an individual basis as recommended by my treating physician. I have the right to discuss the treatment plan with my physician about the purpose, potential risks and benefits of any test or treatment ordered for me. I hereby request to reasonable and necessary medical examinations, testing and treatment.

Patient Signature: ____

Date: ____________________________________

CONSENT FOR FINANCIAL COMMUNICATIONS:
Financial Agreement.

I acknowledge that Houston Acupuncture and Primary Care will not bill my insurance company for services provided to me and I am responsible for the full amount of fees. **I agree to notify Houston Acupuncture and Primary Care if I currently or at any point in the future are covered by Medicare, Medicaid, Tricare or Medicare Advantage plans.** I understand that there is a fee for returned checks and credit card chargebacks.

Third Party Collection. I acknowledge that Houston Acupuncture and Primary Care may utilize the services of a third-party business associate or affiliated entity as an extended business office (“EBO Servicer”) for medical account billing and servicing.

I agree that, in order for Houston Acupuncture and Primary Care, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that Houston Acupuncture and Primary Care or EBO Servicer and collection agents may contact me by telephone at any telephone number I have provided or Houston Acupuncture and Primary Care or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations.

HIPAA Acknowledgement and Consent:

I acknowledge that I have reviewed the practice/clinic’s Notice of Privacy Practice/clinics, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer of the Practice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice/clinic’s Notice of Privacy Practice/clinics.
I agree that Houston Acupuncture and Primary Care may contact me for the purposes of scheduling necessary follow-up visits. I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice’s/clinic’s health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me unless otherwise permitted or required by law.

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: diagnosis and testing information, treatment instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care. I understand that I may opt out of these communications at any time. I

understand that the practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

I understand that the practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care may release my healthcare information for purposes of treatment, payment, or healthcare operations. Healthcare information may be released to my employer's designee when the services delivered are related to a claim under worker's compensation.

Patient Signature: ___________________________________

Date: ____

NOTICE OF PRIVACY PRACTICES:
This notice applies to all of the records of my care generated by Houston Acupuncture and Primary Care ("Practice"), whether made by Practice personnel, agents of the Practice, or healthcare providers at the Practice. I understand that Houston Acupuncture and Primary Care is required by law to maintain the privacy of my health information, provide me a description of the privacy practices, and to notify me following a breach of unsecured protected health information.

Different departments of the Practice may share health information about me in order to coordinate the different things I may need, such as prescriptions, lab work, and x-rays. Houston Acupuncture and Primary Care may also provide my physician or a subsequent healthcare provider with copies of various reports that should assist them in treating me, upon request of that healthcare provider.

Houston Acupuncture and Primary Care may use and disclose health information for Health Care Operations. I understand that members of the medical staff and/or quality improvement team may use information in my health record to assess the care and outcomes in my case and others like it. The results will then be used to continually improve the quality of care for all patients. Houston Acupuncture and Primary Care may also use and disclose health information to remind me of scheduled appointments for medical care, to assess my satisfaction with services, to tell me about possible treatment alternatives, or to tell me about health–related benefits or services, for population-based activities relating to improving health or reducing health care costs, for conducting training programs or reviewing competence of health care professionals.

_______ (Initial if you agree) When disclosing information, primarily appointment reminders and billing/collections efforts, Houston Acupuncture and Primary Care may leave messages on my answering machine/voice mail.

There are some services provided by Houston Acupuncture and Primary Care through contracts with business associates. Examples include radiology services, certain laboratory tests, or electronic medical records. When these services are contracted, Houston Acupuncture and Primary Care may disclose my health information to business associates so that they can perform the job asked of them. To protect my health information, however, business associates are required by federal law to appropriately safeguard my information.

I agree that Houston Acupuncture and Primary Care may release health information about me to a friend or family member who I have indicated is involved in my medical care or who helps me pay for care or to notify, or assist in the notification of (including identifying or locating), a family member, a personal representative, or another person responsible for my care of my location and general condition. I understand that I am solely responsible for notifying Houston Acupuncture and Primary Care of any individuals who should not have access to my information for these purposes. In addition, Houston Acupuncture and Primary Care may disclose health information about me to an entity assisting in a disaster relief effort in order to assist with the provision of this notice. Houston Acupuncture and Primary Care may use or disclose health information for research studies but only when they meet all federal and state requirements to protect my privacy (such as using only de-identified data whenever possible). I may also be contacted to participate in a research study.

Houston Acupuncture and Primary Care may communicate with me via newsletters, mail outs or other means regarding treatment options, health related information, disease-management programs, wellness programs, research projects, or other community-based initiatives or activities the Practice is participating in. Federal and state laws may permit Houston Acupuncture and Primary Care to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share your health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law.

The Practice uses an electronic prescription program to send prescriptions to the pharmacy. This program also includes formulary and benefit transactions, which gives the health care provider information about which drugs are covered by my drug benefit plan. The program also includes fill status notification, which allows the health care provider to receive an electronic notice from the pharmacy telling them if my prescription has been picked up, not picked up, or partially filled. The program also includes medication history transactions, which provides the health care provider with information about my current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens, therapeutic interventions, drug-drug and drug-allergy interactions, adverse drug reactions, and duplicative therapy. I understand that Houston Acupuncture and Primary Care uses this program and that the Practice may request and use my prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.
Houston Acupuncture and Primary Care may disclose information when required to do so by law, and as permitted by law, may also use and disclose health information for the following types of entities, including but not limited to: Food and Drug Administration, Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability, Correctional Institutions, Workers Compensation Agents, Organ and Tissue Donation Organizations, Military Command Authorities, Health Oversight Agencies, Funeral Directors and Coroners, National Security and Intelligence Agencies, Protective Services for the President and Others, a person or persons able to prevent or lessen a serious threat to health or safety, law enforcement officials for purposes such as providing limited information to locate a missing person or report a crime and for Judicial or Administrative Proceedings, such as in response to a court order, search warrant or subpoena. Houston Acupuncture and Primary Care must obtain my written authorization in order to use or disclose psychotherapy notes, use or disclose my protected health information for marketing purposes, or to sell my protected health information. I understand that Texas has separate privacy laws that apply additional legal requirements other than HIPAA, and that Houston Acupuncture and Primary Care will follow these state laws.

I understand that although my health record is the physical property of the healthcare practitioner or facility that compiled it, I have the Right to inspect and obtain a copy of the health information that may be used to make decisions about my care. I understand that I must make this request in writing. Usually, this includes medical and billing records, but does not include psychotherapy notes. Houston Acupuncture and Primary Care may deny my request to inspect and copy in certain very limited circumstances. If I am denied access to health information, I may request that the denial be reviewed. If I feel that health information the Practice has about me is incorrect or incomplete, I may ask the Practice to amend the

information. I have the right to request an amendment for as long as the information is kept by the Practice. I understand that any request for an amendment must be sent in writing. Houston Acupuncture and Primary Care may deny the request for an amendment and if this occurs, I will be notified of the reason for the denial. I understand I have the right to request a restriction or limitation on the health information used or disclosed about me for treatment, payment or health care operations. I also have the right to request a limit on the health information disclosed about me to someone who is involved in my care or the payment of my care, such as a family member or friend. Any request for a restriction must be sent in writing. Houston Acupuncture and Primary Care is required to agree to my request only if 1) except as otherwise required by law, the disclosure is to my health plan and the purpose is related to payment or health care operations (and not treatment purposes), and 2) my information pertains solely to health care services for which I have paid in full. For other requests Houston Acupuncture and Primary Care is not required to agree. Generally, Houston Acupuncture and Primary Care will comply with my request unless the information is needed to provide me emergency treatment. I have the right to request that the Practice communicate with me about medical matters in a certain way or at a certain location. The Practice will grant reasonable requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the Practice and related correspondence regarding payment for services. I understand that Houston Acupuncture and Primary Care reserves the right to contact me by other means and at other locations if I fail to respond to any communication from the Practice that requires a response. I understand I have the right to a paper copy of this notice. I may ask to receive a copy of this notice at any time. Even if I have agreed to receive this notice electronically, I am still entitled to a paper copy of this notice. To exercise any of my rights, I will obtain any required forms from the Practice and submit my request in writing. Houston Acupuncture and Primary Care reserves the right to change this notice and the revised or changed notice will be effective for information already obtained about you as well as any information received in the future.

If I believe my privacy rights have been violated, I understand I may file a complaint with the Privacy Official, the Secretary of the Department of Health and Human Services, or the Texas Office of Attorney General. All complaints must be submitted in writing. I understand I will not be penalized for filing a complaint.

I understand that the uses and disclosures of my health information will be in accordance with state and federal law and that this notice of privacy practices cannot cover every circumstance in which my information may be used or disclosed to others. I understand that I may be required to authorize certain disclosures and, in the event I authorize a disclosure, I can revoke that authorization at any time. I understand that Houston Acupuncture and Primary Care is unable to take back any disclosures already made with my authorization, and is required to retain the records of the care that the Practice provided me.

By voluntarily signing below, I confirm that I have read, or have had read to me, all of the above 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.

SIGNATURE OF PATIENT OR PATIENT AUTHORIZED REPRESENTATIVE

I have received the HIPAA Notice of Privacy Practices.

Signature of Patient (or Representative): ____

Date: _______________________________