Rooted Acupuncture & Wholebeing
218 Shrewsbury Street
Worcester, MA 01604
508-233-3397

Acupuncture Informed Consent to Treat

I understand that I am the decision maker for my health care. Part of Rooted Acupuncture & Wholebeing's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" 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 not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is assumed that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an Oncologist.

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 Lexy Lynch, RYT, M.Ac., Lic.Ac. and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with Lexy Lynch, RYT, M.Ac., Lic.Ac., or serving as back-up for her, including those working at Rooted Acupuncture & Wholebeing 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, electrical stimulation, Tui-Na, Chinese herbal medicine, and nutritional counseling.

I understand that it is not possible to consider every possible complication to care. 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; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include 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. I will notify a clinical staff member who is caring for me if I am, or

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become, pregnant or if I am nursing. Should I become pregnant, I will 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.

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 I must inform, and continue to fully inform, this office of any medical history, family history, medications, 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 if I am receiving any acupuncture or dry needling from practitioners that are not licensed acupuncturists or Medical Doctors in the state of Massachusetts, that I know the risks associated with receiving these treatments and will not hold Rooted Acupuncture & Wholebeing responsible for any harm. I understand that I may be asked to discontinue outside treatments for these liability reasons and accept that I may be asked to discontinue as a patient of Rooted Acupuncture & Wholebeing if I refuse.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, 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. By voluntarily signing below, I confirm 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 agree with the current or future recommendations for care. 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.

Patient Signature (or guardian):	Date:

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Notice of Privacy Practices

This notice describes our office policy for how medical or financial information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share personal, medical, and/or financial information with your insurance company, third party payer, Worker's Compensation (and your employer in this instance), other healthcare practitioners, or with anyone that you authorize.

Types of information that we gather and use:
· Financial information includes your insurance coverage, out of pocket costs, or personal financial arrangement with Rooted Acupuncture & Wholebeing.
· Medical information includes health history, treatment notes, test results, and any letters, emails or telephone conversations with other health care practitioners.
· From health care providers, insurance companies, workman's compensation and your employer, and other third party administrators (requests for medical records, claim payments information).

Types of disclosure: The following are examples of the types of disclosures that Rooted Acupuncture & Wholebeing is permitted to make without specific written consent:
· Medical emergency while at Rooted Acupuncture & Wholebeing office.
· Mandated reporting by Massachusetts law.
· Judicial or administrative proceeding in response to a legal order or other lawful process, including subpoena.

Otherwise, your personal information will only be disclosed after the Authorization for Disclosure of Health/Financial Information Form is signed by you, your guardian, or authorized agent. Upon request, Rooted Acupuncture & Wholebeing will obtain personal information about you only after the Authorization to Obtain Health Information Form is signed by you, your guardian, or authorized agent.

You have the right to review and obtain a copy of your records at Rooted Acupuncture & Wholebeing. There may be a fee associated with copy. You have the right to amend or modify your records if you believe they are inaccurate or incomplete. All requests must be in writing and will be granted if reasonable and appropriate.

Types of communication that we use:

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· Telephone, voicemail messages, texting for emergencies
· Email
· Letters and fax

Safeguards in our office to protect your personal information include:
· Limited access to the office where information is stored.
· Secured network for credit/debit card processing.
· Computer password protection.
· Any business associate of Rooted Acupuncture & Wholebeing that may have access to patient's personal information is required to sign a business agreement. Business associates include any legal firm, accountant, consultant, billing service, volunteers/assistants or other person that may have access to patient's personal information.
· All medical files and records (including telephone, letters, email, and faxes) are stored according to Massachusetts law.
· Telephone voicemail and texting messages will include as minimal information as possible.
· Each fax and email will include a confidentiality statement.

Rooted Acupuncture & Wholebeing values our relationship and respects your right to privacy. If you have any questions about our privacy practices, please ask.

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Consent to the Use & Disclosure of Health Information for Treatment, Payment and Health Care Operations Form

I consent to the use or disclosure of my identifiable health information by Rooted Acupuncture & Wholebeing 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 and treatment of me at Rooted Acupuncture & Wholebeing may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. If Rooted Acupuncture & Wholebeing agrees to a restriction that I request, the restriction is binding upon Rooted Acupuncture & Wholebeing. I have the right to revoke this consent, in writing, at any time except to the extent that Rooted Acupuncture & Wholebeing 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 received and reviewed Rooted Acupuncture & Wholebeing Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Rooted Acupuncture & Wholebeing. This Notice of Privacy Practices also describes my rights and the duties of my practitioner(s) with respect to my identifiable health information.

Rooted Acupuncture & Wholebeing reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices during any office visit. If any changes are made to the Notice of Privacy Practices, the new version will be posted in the office for a period of at least one month. By voluntarily signing below, I have carefully read or have had read to me, the above consent for purposes of treatment, payment, and health care operations. I understand my rights to change this consent at any time.

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Office Procedures & Financial Policies

Financial Policies:

· Payment is required at the time of the visit unless other arrangements have been made in advance. Accepted forms of payment include cash, check, or credit card (MasterCard, Visa, Discover).
· For appointments in the office, the first visit is $130 (75-90 minutes) and each follow-up visit is $85 (45-60 minutes).
· For home visits, the first visit is $180 (75-90 minutes) and each follow-up visit is $120 (45-60 minutes), prices may vary depending on location and time.
· Returned checks will incur a $30.00 fee, payable immediately.

Cancellation Policies:

· 24 hour notice is required to cancel an appointment.
· Individuals are responsible for the full appointment fee if cancellation is made without 24 hours notice.
· If full appointment fee is not paid within 1 week from missed appointment, patient's card on file will be charged for the full amount.

Late Policies:

· We respect your time and other patient's time. If you are late and treated, then the appointment will be shortened and end according to the original start time of the appointment.
· Late patients will be charged the full fee regardless of treatment time.
· If a patient is more than 30 minutes late, they will not receive a treatment and will be responsible for the full appointment fee.

Dismissal Policies:

· Rooted Acupuncture & Wholebeing reserves the right to dismiss patients for any reason, including but not limited to: inappropriate conduct, non or late payment, medical reasons, and safety concerns.

Cell Phone Policies:

· Cell phones are to be turned off or silenced prior to entering the office.
· Talking on a cell phone is not permitted in the office.

Rooted Acupuncture & Wholebeing reserves the right to change information contained in the Office Procedures & Financial Policies at any time. If any changes are made to the Office Procedures & Financial Policies, the new version will be posted in the office for a period of at least one month.

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Credit Card Authorization Form

We will store any credit card used to pay for services on file through a secure payment service (Square). If you are a new patient, you may be asked for your credit card information when scheduling your first appointment. Your card will not be processed for any reason without your consent. You may at any time pay using alternative payment including: cash, check, debit or alternative credit card at the time of visit or missed visit. Please know that your card will be charged for a no-show visit if you do not provide an alternative payment method within one week of scheduled/missed appointment.

Cancellation policy: 24-hours. This allows Rooted Acupuncture & Wholebeing to fill your appointment time with another patient off of a wait list if and when possible. If given less than 24-hours, we reserve the right to charge your full appointment fee depending on whether or not we can fill your appointment spot.

You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

I, _____, understand that if I pay by credit card, my information will be saved to file for future transactions on my account. I authorize Lexy Lynch, M.Ac., Lic.Ac. to charge my credit card above for agreed upon purchases including treatments or missed appointment fees.

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Patient Photo Release Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.

This release is strictly designated to give permission to any associates of Rooted Acupuncture & Wholebeing to take and use photos during my Acupuncture appointment(s). I will allow these photos to be shared with other professionals and patients in an educational setting, or on social media sites (Twitter, Facebook, Instagram, LinkedIn, etc.) Rooted Acupuncture & Wholebeing will have permission to use these photos in the manner described above unless I request to no longer use them. A written request form is available to do so. I understand that I have the option to decline this request, and am not obligated in any way to provide permission to use these photos.

I will allow Lexy Lynch, Lic Ac. to share my digital patient photos with other patients and/or professionals in an educational setting or for social media/marketing purposes. I understand that at no time will my face be shown; or any other identification factors unless with my verbal consent. These photos will not be sold or used in marketing material with the intention of being sold.

Patient Signature (or guardian):	Date:

☐ I prefer photos not be taken or used for any purpose.