Summary of Privacy Practices

This notice summarizes how health data about you may be used and shared and how you may access this data. We have a complete NOTICE OF PRIVACY PRACTICES that is available in our office if would like to read the complete details.

I. How we may use and share health data about you:

a) Treatment - To give you medical treatment or other types of health services.

b) Payment - To bill you or a third party for payment for services provided to you.

c) Health Care Operations - For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:

a) To you

b) As required by federal, state, or local law

c) If child abuse or neglect is suspected

d) Public health risks (for public health activities to prevent and control spread of disease) e) Lawsuits and disputes (in response to a court or administrative order)

f) Law enforcement (to help law enforcement officials respond to criminal activities)

g) Coroners, medical examiners and funeral directors

h) Organ or tissue donation facilities if you are an organ donor

i) To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:

a) Patient directories - You can decide what health data, if any, you want to be listed in patient directories.

b) Persons involved in your care or payment for your care - We may share your health data with a family member, a close friend or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:

a) Right to inspect your health record and to receive a copy of your health record upon request b) Right to amend information in your health record you believe is inaccurate or incomplete c) Right to know to whom we have disclosed your health information

d) Right to ask for limits on the health information data we give out about you

e) Right to receive communication from us about your health information in alternate ways

f) Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have read this SUMMARY OF PRIVACY PRACTICES and understand that I may request the full NOTICE OF PRIVACY PRACTICES document from The Bow Acupuncture & Community Wellness, LLC at any time.

_____

Signature of Patient or Representative Date

HIPAA Acknowledgement and Appointment Reminders

I acknowledge that I have been provided access to the The Bow Acupuncture & Community Wellness, LLC's "Notice of Privacy Practices". I understand that I have the right to review the "Notice of Privacy Practices" prior to signing this document.

I understand that The Bow Acupuncture & Community Wellness, LLC staff members and associates may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and I am not at home, a message will be left on my answering machine or with anyone who answers the phone.

Information stripped of any personal identifiers may also be used for research and educational purposes by individual practitioners. By signing this form, I am giving The Bow Acupuncture & Community Wellness, LLC authorization to contact me with these reminders and to utilize my information for research and educational purposes.

_____

Patient Name (print) Date

_____

Signature

New Patient Information

Cancellation Policy - Treatments are by appointment, although we can sometimes accommodate walk-ins. Should the clinic need to close due to inclement weather or other severe circumstances, The Bow Acupuncture & Community Wellness, LLC will post the closing or schedule change on its website. If you find that you need to cancel an appointment, it is important that we receive 24-hour notice. This enables us to fill the time slot. **We reserve the right to charge the full fee for an appointment canceled with less than 24-hour notice or for a "no show" appointment.** We will use our discretion when charging "No Show" fees. Also, the clinic reserves the right to charge the full scheduled fee for tardiness to appointments.

Payment for Clinic Services Rendered - Payment is due at the time of service and may be paid in cash, with most major credit cards, a medical savings account card, flexible spending account card or health savings accounts card. We do not file insurance claims of any kind and are not a Medicare/Medicaid provider. Upon request, we will happily provide you with a printed receipt containing the necessary information enabling you to file your claim. Thank you for allowing us to provide you with quality health care.

_____

Patient Signature Date

Name:_____

Birthdate:_____Age:_____

How did you hear about us?_____

Email(required)_____

Phone(s):_____

Address:_____

City:_____State:_____Zip:_____

Occupation/Company:_____

Emergency Contact:_____

(Relation, Phone)_____

Chief Complaints

1)_____

2)_____

3)_____

Allergies:_____

Medications:_____

(Circle) **Pregnant Pacemaker HIV AIDS Hepatitis**

Pain Level (Circle) 1 2 3 4 5 6 7 8 9 10

Frequency of pain: 25% 50% 75% 100% of the time

Digestion (circle): Constipation Diarrhea gas upset stomach

Chronic medical conditions: diabetes, heart disease or high blood pressure, etc?_____

Past surgeries:_____

Energy (circle): Great Ok Poor

Sleep (circle): Great Ok Poor

Emotions (circle): Stress Irritable Anger Frustration Sadness Grief Worry Anxiety Panic Restless Mental Illness

I tend to feel (circle): Hot Cold

Libido: Great Ok Needs Help

Women's Health (circle):

Endometriosis Fibroids Ovarian Cysts Breast Cysts Hormone Replacement Therapy Hysterectomy Menopause

On Menstrual Period, I experience: No Period Bloating Clots Swollen/Tender Breasts Back Pain Upset Stomach

Mood change (circle): Before/during/after

Cramps (circle): Before/during/after

Primary Physician & #_____

Informed Consent to Treatment: I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by the licensed acupuncturists on staff at The Bow Acupuncture & Community Wellness, LLC who now or in the future treat me while employed by, working or associated with or substituting for The Bow Acupuncture & Community Wellness, LLC, including those working at this clinic or any other associated clinics: acupuncture and other Oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle and orthopedic testing; modes of manual or physical therapy such as body work, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation; cupping and/or moxibustion; the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendations; cosmetic acupuncture; exercise advice and healthy lifestyle recommendations. **I understand** I have opportunities to discuss with my professional practitioners, and/or with other clinic personnel the nature and purpose of acupuncture and Oriental medical procedures. Although I am aware that acupuncture and the other procedures used in Oriental medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied. **I understand and am informed** that, as in the practice of conventional Western medicine, in the practice of Oriental medicine there are some risks to treatment. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, pain or other strong sensation at the location of where a needle is inserted or radiating from that location, nerve pain, burns, aggravation of current symptoms, appearance of new symptoms and general aches. Other very uncommon but possible risks include pneumothorax, puncture of other organs, sprains, strains, dislocation, fractures, disc injuries and strokes. I do not expect the practitioners to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioners to exercise such judgment, during the course of my treatment, as the practitioner feels at the time, based on the facts then known, to be in my best interest.

I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures and conditions of treatment. 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 at The Bow Acupuncture & Community Wellness, LLC.

Signature_____ **Date**_____

Welcome to The Bow Acupuncture! Please Read this Brief Introduction to Our Clinic...

When you receive acupuncture treatment at our community clinic you are not just a patient, you are a participant. We are one of many clinics around the country in recent years to provide accessible acupuncture by offering treatment in a group setting with a sliding scale pay structure. Acupuncture works best when received on a consistent basis and some treatment plans will require multiple treatments in a week. We want to make it affordable for you to get the treatments you need!

Community Acupuncture is **Community Supported Acupuncture** (we don't receive any grants or other funding to do what we do). By supporting this clinic, you are participating in making the benefits of acupuncture accessible to more people than previously possible. Thank you for being here!

Guidelines:

- Please whisper or speak softly in the treatment room.
- Phones must be silenced completely, turned off, or left in your car. (Very Important!)
- Please do not wear cologne, perfume, or strong smelling body products. Many patients are allergic.
- You may listen to music or a meditation on your phone/iPod (with headphones) during your treatment.
- Wear loose clothing that can be pushed or rolled up to access your legs and arms (shorts and tank tops are perfect).
- Don't come to your treatment feeling very hungry or with a very full stomach.
- We recommend not consuming caffeine or smoking directly before your treatment.
- Allow about 60-90 minutes from check-in to check-out (treatments can be as shorter if your time is limited).

Our Sliding Scale Philosophy $15-$35:

We operate on a sliding scale basis in order to make acupuncture affordable for everyone. We do not require proof of income. You can base your choice of what you pay using your income as a guideline, but remember the scale is flexible. We understand everyone's financial situation is different and we want you to pay at a level that allows you to comfortably receive the treatments you need. You can ask your acupuncturist about your recommended treatment plan.

- It is most important to pay at a level so that you can comfortably afford to get the number of treatments you need. Take this into consideration when choosing your level on the sliding scale.
- The way we can charge so little and still make a living ourselves is by treating multiple patients in an hour. We'd appreciate you helping to spread the word about community acupuncture so we can help more people!
- You can change how much you pay at any time, for any reason, no questions asked.
- Cash / Check / Credit accepted. We do not bill insurance but can provide you with a receipt.

Select how much you pay ----------↓

If Your Income Is:	**We Suggest You Pay:**	**Additional Treatments in the Same Week:**	**CHECK ONE:**
< $20,000 per year	**$15**	+ $15	☐
> $20,000 - $25,000 per year	**$20**	+ $15	☐
> $25,000 - $30,00 per year	**$25**	+ $20	☐
> $30,000 - $40,000 per year	**$30**	+ $20	☐
> $40,000 per year	**$35**	+ $25	☐

There is an additional $10 new patient administrative fee on your first appointment.

Cancellation Policy Agreement: If you have an appointment scheduled and you don't show up and don't call us prior to the appointment to let us know you won't be coming, we reserve the right to charge a missed appointment fee of $10. Please cancel your appointment online, by phone or email so that we can fill the spot.

I have read and agree to the above:

Name Signature Date