

## CONSENT TO TREAT

*Please take the time to read through the following information carefully and completely, and ask us any questions you have about the content before signing your consent at the bottom of the page.*

I, \_\_\_\_\_, hereby authorize Molly Connelly, LAc. to perform any of the following procedures as necessary to give proper assessments, determine treatment approaches, and treat or otherwise address my health concerns:

### *Methods, Procedures and Therapeutic Approaches*

- **General Diagnostic Procedures:** including but not limited to general physical exam, observation, palpation, and musculoskeletal assessments.
- **Acupuncture:** insertion of sterilized, disposable needles at specific points on the body.
- **Topical Treatments/Soft Tissue Manipulation:** including gua sha, a dermal friction therapy; and cupping, a technique using glass suction cups on the surface of the skin; cupping may be used in conjunction with bloodletting, in which a needle is briefly inserted in the skin to a shallow depth, and a small amount of blood (usually a few drops) is expressed from the puncture site.
- **Heat Treatments:** includes heat treatments using moxibustion and/or an infrared heat lamp. Moxibustion involves the use of a slow burning Chinese herb for direct or indirect warming of an acupuncture point.
- **Electromagnetic Treatment:** includes the use of electrical stimulation, polarity devices and/or magnets applied to acupuncture points.

**Potential Risks:** discomfort, pain, bruising, skin discoloration, aggravation of pre-existing symptoms and lightheadedness are side effects that are occasionally encountered with needle insertions, topical procedures, soft tissue manipulation, thermal therapies, and/or electromagnetic therapies. Blistering, burns, infection, loss of consciousness and deep tissue injury are adverse effects that rarely occur with needle insertions, topical procedures, soft tissue manipulation, thermal therapies, and/or electromagnetic therapies.

**Potential Benefits:** Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in recovery from disease and injury, and prevention of disease or its progression.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me regarding cure or improvement of my condition. I also understand that any diagnosis given in the context of acupuncture treatment does not constitute a Western medical diagnosis, and that recommendations may be made to pursue further medical advice or intervention if necessary. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or me or otherwise permitted or required by law.

Signature of Patient, Guardian or Legal Representative:       X  \_\_\_\_\_

Printed Name of Patient, Guardian or Legal Representative: \_\_\_\_\_

Date: \_\_\_\_\_

Practitioner Signature: \_\_\_\_\_

# Health History Form

## Patient Information and Contact Information

<b>Date</b> _____	<b>Day Phone</b> _____
<b>Name</b> _____	<b>Evening Phone</b> _____
<b>Address</b> _____	<b>Email</b> _____
<b>City, State, Zip</b> _____	<b>Insurance Plan</b> _____
<b>Age</b> _____ <b>Birthdate</b> _____	<b>ID #</b> _____
<b>Marital status</b> _____	<b>Group#</b> _____
<b>Occupation</b> _____	<b>Emergency Contact Person</b>
<b>Company Name</b> _____	<b>Name</b> _____
<b>Primary Physician</b> _____	<b>Relationship</b> _____
<b>Referred By</b> _____	<b>Phone Number</b> _____

What is your main reason for coming to acupuncture today? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In what ways does this condition interfere with your daily activities? \_\_\_\_\_

\_\_\_\_\_

Have you been given a diagnosis for this condition? If so, what? \_\_\_\_\_

\_\_\_\_\_

What other kinds of treatments (if any) have you tried for this? \_\_\_\_\_

\_\_\_\_\_

Please list any allergies and/or skin sensitivities (i.e. drugs, chemicals, foods, environmental etc.): \_\_\_\_\_

Please list any medications, supplements, vitamins and/or herbs that you are currently taking, or take as needed: \_\_\_\_\_

\_\_\_\_\_

**Past Medical History:** (please circle all that apply and include dates)

**Significant Illnesses:** Cancer Diabetes Hepatitis High Blood Pressure Auto Immune  
Heart Disease Rheumatic Fever Thyroid Disease Seizures Candida HIV AIDS  
Other: \_\_\_\_\_

**Family Medical History:** Diabetes Cancer High Blood Pressure Mental Illness  
Alcoholism Heart Disease Seizures Asthma Allergies Auto Immune Diseases  
Other: \_\_\_\_\_

**Surgeries:** (please indicate dates:)  
\_\_\_\_\_  
\_\_\_\_\_

**Significant traumas/injuries:** (auto accidents, broken bones, whiplash etc.):  
\_\_\_\_\_  
\_\_\_\_\_

**Please check any of the following you have experienced in the last 6 months:**

<input type="checkbox"/> Allergies	<input type="checkbox"/> Disc problems	
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diverticulitis	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Headaches	<input type="checkbox"/> Respiratory difficulty
<input type="checkbox"/> Back pain	<input type="checkbox"/> Herpes Virus	<input type="checkbox"/> Sciatica
<input type="checkbox"/> Chest pain	<input type="checkbox"/> IBS	
<input type="checkbox"/> Circulation problems	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Sleep difficulty
<input type="checkbox"/> Colitis	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Sprains/Strains
<input type="checkbox"/> Constipation	<input type="checkbox"/> Migraines	<input type="checkbox"/> Stiff joints
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Muscle spasms	<input type="checkbox"/> Swollen feet
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Numbness	<input type="checkbox"/> Tendonitis
<input type="checkbox"/> Digestive problems	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Tingling

**Additional Comments:** Please describe any other conditions which you would like to discuss:  
\_\_\_\_\_  
\_\_\_\_\_

## Office Policies

### Late Arrivals

A shortened treatment is less effective, so if you are **more than 10 minutes late**, you will probably be asked to reschedule.

### Cancellations/Rescheduling

You may cancel or reschedule your appointment up to **4 hours** before your scheduled time. We understand that traffic, childcare, weather etc. emergencies happen, so we don't charge late fees or no-show fees; however, if you are having ongoing difficulty with arriving as scheduled, we may refer you to a different clinic.

### Rates and Payment

	<b>Cash Rates</b>	<b>Medical Insurance Rates</b>
<b>First Visit</b>	\$65 - \$75 (depending on complexity of treatment)	\$75 - \$95 (depending on complexity of treatment)
<b>Return Visits</b>	\$35 - \$50 (depending on complexity of treatment)	\$40 - \$80 (depending on complexity of treatment)

Payment can be made with cash or check. We are **preferred, in-network providers** with Aetna, CIGNA, First Choice, American Specialty Health, Lifewise, and Premera Blue Cross. If you have **out-of-network** benefits we can also bill Group Health and Regence plans. **We are not currently accepting Personal Injury claims.** If you have health insurance that covers acupuncture we will gladly submit your claims for you. You are responsible for your deductible, your co-pay and co-insurance amounts. If your insurance denies payment of a claim, you are responsible for the billed charges. We submit billing promptly, so that any payment problems can be quickly identified, and we make every effort to avoid any accumulation of charges. If you have a Health Savings Account, we can give you a detailed receipt that you can submit to your Human Resources department.

\*\*\*\*\*

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

Signature **X** \_\_\_\_\_ Date: \_\_\_\_\_

# PRIVACY PRACTICES ACKNOWLEDGMENT

## ACKNOWLEDGMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

## **NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This notice takes effect on 11/01/06 and remains in effect until we replace it.

### **1. OUR PLEDGE REGARDING MEDICAL INFORMATION**

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our clinic. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

### **2. OUR LEGAL DUTY**

#### **Law Requires Us to:**

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

#### **We Have the Right to:**

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

#### **Notice of Change to Privacy Practices:**

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

### **3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION**

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

**FOR TREATMENT:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

**FOR PAYMENT:** We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

**FOR HEALTH CARE OPERATIONS:** We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

---

**ADDITIONAL USES AND DISCLOSURES:** In addition to using and disclosing your medical information for treatment, payment and health care operations, we may use and disclose medical information for the following purposes.

**Notification:** We may use or disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment.

**Disaster Relief:** We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

**Research in Limited Circumstances:** We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

**Funeral Director, Coroner, Medical Examiner:** To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

**Specialized Government Functions:** Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the president and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

**Court Orders and Judicial and Administrative Proceedings:** We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

**Public Health Activities:** As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

**Victims of Abuse, Neglect, or Domestic Violence:** We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

**Workers Compensation:** We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

**Health Oversight Activities:** We may disclose medical information to an agency providing health oversight for oversight activities required by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

**Law Enforcement:** Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crime at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

**Appointment Reminders:** We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

**Alternative and Additional Medical Services:** We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

## 4. YOUR INDIVIDUAL RIGHTS

### You Have a Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you \$ 0.10 for each page, and postage if you want the copies mailed to you.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment and health care operations and other specified exemptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information, We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

## QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights in Section 4 of this notice by writing to us at the following address:

**MOLLY CONNELLY, LAC.  
PRIVACY OFFICER  
5410 CALIFORNIA AVE SW, SUITE 202  
SEATTLE, WA 98136**

The address to file a complaint with the U.S. Department of Health and Human Services is:

**US DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF CIVIL RIGHTS  
200 INDEPENDENCE AVE SW  
WASHINGTON, DC 20201**

**Toll-Free Number: 1-877-696-6775**

