Zócalo Wellness
(503) 724-4321
info@zocalowellness.org

Acupuncture Informed Consent to Treat

I hearby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of Chinese medicine on me (or on the patient named below, for whom I am legally responsible) by the Licensed Acupuncturist, Adrianna Locke.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, bodywork/massage, Chinese herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needle sites that may last up to a few days, 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 also a common side effect of cupping, which may last up to a week to 10 days. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another unusual risk, and this clinic uses sterile and disposable needles and maintains a clean and safe environment to further minimize this risk.

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. Some possible side effects of taking herbs are nausea, gas, stomach pain, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify Adrianna Locke if I am or become pregnant.

While I do not expect Adrianna Locke to anticipate and explain all possible risks and complications of treatment, I wish to rely on Adrianna Locke to exercise judgment during the course of treatment which is in my best interest. I understand that results are not guaranteed.

While doing community or group acupuncture I understand that there is a risk of other patients overhearing my discussion with my acupuncturist and that the acupuncturist will do her best to limit discussion of sensitive topics in the group treatment area.

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 being treated in a community setting, precautions will be made to keep my health information private but that other patients may overhear.

By voluntarily signing below, I show 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 intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Acupuncturist Name: Adrianna Locke, LAc

Patient Printed Name: _____ **Date:** _____

Patient Signature: _____
(Or patient representative, indicate relationship if signing for patient)

Zócalo Wellness
(503) 724-4321
info@zocalowellness.org

HIPAA Notice of Privacy Practices

Please review this notice carefully. It describes how medical information about you may be used and disclosed and how you can get access to this information.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment of health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your PHI may be used and disclosed by your health care provider, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the health care provider's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining reimbursement from your insurance company will require your PHI to be disclosed.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your health care provider's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your health care provider. We may also call you by name in the waiting room when your health care provider is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

Use Required by Law: We may use or disclose your PHI in the following situations without your authorization: required by law; public health issues as required by law; communicable diseases, health oversight, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, required uses and disclosures. Under the law, we must make disclosures to you as required by the Secretary of the Department of Health and Human Services.

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your health care provider or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Patient Printed Name: _____ **Date:** _____

Patient Signature: _____
(Or patient representative, indicate relationship if signing for patient)