Acu Pop-Up Informed Consent

By signing below, I do hereby voluntarily request and consent to the performance of acupuncture treatments by Jennifer Ward, LAc of Acu Pop-Up/Being Elemental. I understand that acupuncturists practicing in the state of Oregon are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

Acupuncture: I understand that acupuncture is performed by the insertion of needles through the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, minor bleeding, pain or discomfort, numbness or tingling near the needling sites that may last a few days, dizziness or fainting. and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time. Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment. I understand the clinician may review my patient records but all my records will be kept confidential and will not be released without my written consent.

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 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: _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Phone:** _____

NOTICE OF PRIVACY PRACTICES

This notice describes our company's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected. Below are the methods in which we secure your information confidentially in accordance with the Health Insurance Portability and Accountability Act (HIPAA). The patient's chart is secured in a locked file in the offices of Acu Pop-Up. Should we meet outside of the clinic, we will not acknowledge how we are acquainted unless you infer consent through introduction, etc. It is our preference to discuss your health only within Acu Pop-Up settings to protect your privacy and to ensure that important information is documented in your chart. Consent from the patient is required either verbally or in writing to allow for the sharing of the patient's private information. Your confidential healthcare information is private and will not be copied and shared with anyone else without your written, signed consent. In some cases, if time does not permit, your verbal approval may be accepted after proper identification is acquired. Copies of released records are sent by mail or fax. A confidential patient information cover sheet accompanies all faxes. I have read and understand my right to privacy, as stated above, and agree to have the Jennifer Ward/Acu Pop-Up maintain my records confidentially in accordance with the law. I agree to inform Jennifer Ward/Acu Pop-Up if I need any special arrangements pertaining to this issue. Jennifer Ward/Acu Pop-Up 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 by accessing the website or requesting the most current notice during any office visit.

Signature of Patient: _____
Date: _____
Printed Name: _____