Westside Family Acupuncture

Medical - Personal - Family History

Name: _____ Date:_____

Primary Care Doctor/Referring Provider_____ Office Location_____

*Main health issue(s)*_____

*When did the issue start?*_____ If a musculoskeletal issues, which side of body? (Left) (Right) (Both)

Have you been treated or are you now being treated for this by another healthcare provider? (Y) (N)

Do you bruise or bleed easily? (Y) (N) Do you have a Pacemaker (Heart)? (Y) (N)

How do you feel about receiving acupuncture? ( ) I've had it before ( ) Fine) ( ) Concerned ( ) I don't know

Do you have any infectious diseases? (ex. AIDS/Hepatitis/Staph) **(Y) (N) List** _____

Females only: Are you pregnant or is it possible that you could be pregnant? (Y) (N)

Medical Status / History

☐ High / Low Blood Pressure
☐ Diabetes / Pre-diabetes
☐ High Cholesterol
☐ Heart Attack / Stroke
☐ Fatty Liver
☐ Liver / Gall Bladder Disease
☐ Emotional Issues
☐ Arthritis OA - RA
☐ Thyroid Hypo - Hyper
☐ Kidney Disease
☐ COPD - Asthma
☐ COPD - Chronic Bronchitis
☐ COPD - Emphysema
☐ Cancer
☐ Insomnia
☐ Sleep Apnea
☐ Chronic Fatigue
☐ Chronic Pain
☐ Allergies / Sinuses
☐ Smoker
☐ Alcoholism

Family History

☐ Heart Disease
☐ Diabetes
☐ Cancer
☐ Other_____
☐ Obesity
☐ Stroke
☐ High Blood Pressure
☐ Other_____
☐ Allergies
☐ Heart Attack
☐ COPD
☐ Other_____

List any past traumas (ex.Car accidents/Falls)

_____

_____

_____

List surgery/hospitalizations w/approx. dates

_____

_____

_____

_____

List Other Medical Conditions / Allergies

_____

_____

_____

☐ **Provide a list of your current Medications**

WORK & SOCIAL SUPPORT

Occupation:_____

Retired ____ Student ____ Unemployed_____

Employed by:_____

Do you enjoy your work?
☐ Always ☐ Usually ☐Rarely ☐ No

My family/social support network is:
☐ Non-existent ☐ Adequate ☐Good ☐Great

My stress level is:
☐ Overwhelming ☐ High ☐ Mild ☐Low

I feel my life is:
☐ Significant /Meaningful ☐ Stagnant ☐ Fine
☐ In need of direction/support

Covid 19 - Do you Need Help...
☐ I have no concerns, I am doing well
☐ I had Covid 19 and/or the Vaccine
☐ I am still affected by Covid 19
☐ I am still affected from the Vaccine

DRUG LIST & FURTHER MEDICAL HISTORY

Please list prescription and over-the-counter medications you are taking (Or Provide a list)

Drug Name	Taking it for (what condition)	For How Long	Dosage (how much)	Frequency (how often)

Please Check Any Recent Symptoms Within the Past 6 weeks

Head - Ears -Eyes Nose - Throat	**Respiratory**	**Cardiovascular**	**Gastrointestinal**
☐ Headaches	☐ Frequent Colds	☐ High Blood Pressure	☐ Heart Burn
☐ Impaired vision	☐ Persistent Cough	☐ High Cholesterol	☐ Abdominal Pain
☐ Dry or Tearing Eyes	☐ Difficult Breathing	☐ Low Blood Pressure	☐ Nausea/Vomiting
☐ Hearing Loss	☐ Shortness of Breath	☐ Heart Disease	☐ Ulcers
☐ Ear Ringing	☐ Asthma	☐ Chest Pain	☐ Poor Appetite
☐ Sinus Problems	☐ Pneumonia	☐ Palpitations	☐ Strong Appetite
☐ Nose Bleeds	☐ Emphysema	☐ Edema	☐ Passing Gas
☐ Sore Throat	☐ Heavy Chest	☐ Stroke	☐ Gall Bladder Stones
☐ Dry Throat	☐ Tight Chest	☐ Heart Attack	☐ Hemorrhoids
☐ TMJ or Grinding Teeth	☐ Congested Chest		☐ Change in Bowels
	☐ COPD		

Genito-Urinary Track	**Neurological**	**Musculo-Skeletal**	**Psychiatric**
☐ Kidney Disease	☐ Vertigo/Dizziness	☐ Neck/Shoulder Pain	☐ Clinical Depression
☐ Kidney Stones	☐ Paralysis	☐ Upper Back Pain	☐ Mood Swings
☐ Painful Urination	☐ Numbness/Tingling	☐ Mid Back Pain	☐ Panic Attacks
☐ Dribbling Urination	☐ Loss of Balance	☐ Low Back Pain	☐ Nervousness
☐ Frequent Urination	☐ Seizures/Epilepsy	☐ Leg Pain	☐ Anxiety
☐ Blood in Urine	☐ Headaches	☐ Muscle Spasms	☐ Frustration/Anger
☐ Frequent UTI	☐ Bell's Palsy	☐ Arthritis	☐ Sadness
☐ Incontinence	☐ Trigeminal Neuralgia	☐ Joint Pain	☐ Alzheimer's
	☐ Peripheral Neuralgia	☐ Osteoporosis	☐ Dementia

Constitution	**Allergies/Immunologi**	Other Symptoms: List anything you feel is helpful
☐ Low Energy	☐ Chronic Sinusitis	
☐ Poor Sleep	☐ Seasonal Allergies	
☐ Weight Gain	☐ Chronic Allergies	
☐ Weight Loss	☐ Medication Allergies	
☐ Chills	☐ Weak Immune Sys.	
☐ Fevers	☐ Aids	
	☐ Hepatitis	

☐ Reviewed and Signed by Doctor Date: _____ ☐ Updated: _____

Doctor's Sign: _____

Comment Pertinent Findings:_____

_____

Westside Family Acupuncture Inc.
5115 Coors Blvd. Ste. E Albuquerque, NM 87120
505-897-6560 / Fax 505-715-5537
www.abqacu.com / abqacu@gmail.com

PERSONAL INFORMATION

PLEASE PRINT LEGIBLY & ANSWER ALL QUESTIONS

Name: Last _____First_____MI_____

Date of Birth_____ Gender _____ Status: Single/ Married/ Partner/ Divorced/ Widowed

Mailing Address _____
City_____State_____ Zip+4_____

Primary Phone _____ Cell / Home / Other

E-mail_____

Appointment reminders preferred by email_____, text_____ or phone call_____. May we leave a message YES / NO?
(If email or text checked, please remember to confirm your appointment when notified).

Emergency Contact: Name_____Relationship to Patient_____

Emergency Contacts Primary Phone_____Work Phone_____

How did you hear about us? Saw Location/ Website/ Insurance/ Google Search/ Flyer/ Other:_____

PATIENT FINANCIAL RESPONSIBILITY STATEMENT/INFORMATION

PLEASE READ CAREFULLY, SIGN or INITIAL in AREAS MARKED,
ANSWER QUESTIONS, FULLY WHETHER THEY APPLY OR NOT

Are we billing your medical insurance? Y / N
Is this your primary insurance? Y / N
Do you have secondary insurance? Y / N
Do you have a deductible? Y / N
Do you have an out of state policy? Y / N
Insurance Company? _____

Primary Card Holder Name _____ Self/ Spouse/ Parent/Guardian of minor

Primary's DOB_____ Primary's Phone _____

Primary's address (If different) _____

The medical services you (the patient) are seeking imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. If someone else (parent, spouse, domestic partner, etc.) is financially responsible for your expenses or carries your insurance, please explain this policy to them, as it explains our practices regarding insurance billing, copayments, and patient billing. By signing, initialing below and/or receiving medical services from Westside Family Acupuncture (WSFA) you acknowledge and/or agree (regardless if using insurance or paying out-of-pocket):

(Initial)_____You are responsible for all payment obligations arising out of your treatment and guarantee payment for these services. You are responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by your insurance carrier or our financial policies, which are otherwise not covered by insurance.

Westside Family Acupuncture Inc.

5115 Coors Blvd. Ste. E Albuquerque, NM 87120
505-897-6560 / Fax 505-715-5537
www.abqacu.com / abqacu@gmail.com

(Initial)_____As a courtesy, we may verify your insurance benefits or submit our claim to your insurance carrier. You acknowledge that you are responsible for knowing your insurance policy and what services are covered. For example, you will be responsible for total charges billed, agree to pay for services and the amounts deemed non-covered or not authorized if the following apply: (a) your health plan requires prior authorization or referral by a primary care provider before receiving treatment at WSFA, and you have not obtained such an authorization or referral; (b) you receive services in excess of such authorization, referral, or visit limit; (c) your health plan determines that the treatments you received at WFSA are not medically necessary and /or not covered or deemed out of network by your insurance plan; (d) your insurance coverage has changed, lapsed or expired at the time you received treatment at WSFA; or you have chosen not to use your insurance coverage. If you are not familiar with your insurance plan coverage, we recommend you contact your carrier or plan directly.

(Initial)_____ Without waiving any obligation to pay, you assign to WSFA, for application onto your bill for services, all of your rights and claims for the medical benefits to which you, or your dependents are entitled, under any federal or state healthcare plan, insurance policy, or other similar third-party payer arrangement that covers healthcare cost of services provided to you. You authorize WSFA and its associated staff to release patient information acquired in the course of your examination and/or treatment including but not limited to any and all medical records, notes, or other documents related to your treatments (including itemization of any charges and payments) that is deemed necessary to process this claim to the necessary insurance companies, third party payers, or other entities as they require to participate in your care. It is important that you notify us immediately of any changes related to your insurance coverage/eligibility. Failing to do so will result in unpaid claims, and you will be responsible for the balance of the claim. WSFA does not accept responsibility for incorrect information given by you or your insurance carrier regarding your insurance benefits or benefit plans.

(Initial)_____I understand that office visit charges are payable on the day service is rendered. I authorize WSFA, to bill my insurance company. Regardless of insurance coverage quoted or paid, I am responsible for all bills being paid in a timely manner. I understand that my contract is between WSFA and myself. I understand that according to my insurance carrier contract, there may be co-pays and/or deductibles in addition to co-insurance amounts that will be payable during the time that services are rendered. I understand that WSFA has no knowledge of deductible amounts already met. I have been informed that WSFA can provide me with an estimate of my deductible liability at the time of my visit by direction of my insurance company. I understand that these charges under the deductible owed may be significant and include total charges billed.

(Initial)_____Once your insurance carrier processes your claim, we will bill you for any remaining patient responsibility deemed by your insurance carrier, if any payment is made directly to you for services billed by us; you agree to promptly submit same to WSFA until your account is paid in full. When possible, billing your insurance is done as a courtesy. As such, if your insurance is billed and there is a problem with how they pay, it is your responsibility to contact your insurance carrier to resolve any discrepancies. If you make a payment that results in a surplus on your account, you authorize WSFA to apply the overpayment first, to any other account for which you are financially responsible, including your account, a member of your family or dependents' account, or on any account for which you are the financial responsible party, second, hold as a credit for future appointments, then third, refund the remaining balance to you.

(Initial)_____Whether or not you have insurance or are self-pay (TOS), your portion is due at time of service and payment of any account balance is due upon receipt of your billing statement and will be considered late at thirty (30) days of receipt of billing statement. You must notify us of any errors or objections to the billing statement within twenty (20) days or they will be deemed accurate, and the fees and expenses shall be deemed reasonable and necessary for the services incurred. If there is a problem with your account it is your responsibility to contact WSFA and its associated staff to address the problem or to discuss a workable solution. If any balance on your account is over ninety (90) days past due, your account will be in default and will be sent to collections. You may incur additional fees and charges for collection services in addition to your balance owed.

Westside Family Acupuncture Inc.

5115 Coors Blvd. Ste. E Albuquerque, NM 87120
505-897-6560 / Fax 505-715-5537
www.abqacu.com / abqacu@gmail.com

(Initial)_____Self-pay policy (TOS). We offer a prompt pay rate for services paid in full at the time of service. This discount is based on the administrative savings to our practice when receiving payments up front rather than billing for services. We will not bill your insurance company for services provided under this arrangement. No forms will be produced now or in the future for you to submit claims for insurance billing.

CANCELLATION POLICY

We understand that emergencies do occur and we do not wish to penalize patients for unavoidable situations. However, to be fair to everyone accordingly, we record all appointments, last-minute cancellations, and no-shows, and discourage repeat abuse of our schedule. Last minute cancel/reschedule is defined as the following: If you cancel/reschedule your appointment with less than 24-hour notice (or after close of business on Friday for Monday appointments) or no-show you will be sent a warning letter and could face additional fees.

(Initial) _____If you are unable to keep your appointment, please notify the office within 48 hours. If possible, a minimum of 24 hours (or before close of business on Friday for Monday appointments) is required for canceling/rescheduling an appointment to avoid a $70.00 fee. If you have accumulated 3 or more last minute cancellations or no-shows, a $70 fee will apply and future appointments will require a $70.00 deposit which will go towards charges for your treatment.

(Initial)_____ A cancellation or no-show for **ALL SAME DAY** appointments will automatically be billed $70.00.

(Initial)_____ A last minute cancellation or no-show for **ALL SATURDAY** appointments will automatically be billed $85.00.

Our policy for VA missed / last-minute cancellation of appointments is the following:

1. First missed appointment: Warning letter sent out to you.
2. 2nd missed appointment: VA will be notified and a letter sent out to you.
3. 3rd missed appointment: All future appointments will be canceled and VA will be notified.

(If your answer is no to the questions below, mark accordingly, and proceed to each section, then sign and date [signature is acknowledging entire document]).

Is treatment related to an employment injury? Y / N If yes, are we billing Workman's Compensation? Y / N
(**IF WE ARE BILLING YOUR WORKER'S COMPENSATION, WE REQUIRE ADDITIONAL PAPERWORK PRIOR TO TREATMENT. PLEASE ASK RECEPTIONIST).**

Is treatment related to a personal injury Y / N or auto accident? Y / N What was the date of your injury?_____
(**IF WE ARE BILLING A PERSONAL INJURY OR AN AUTO INSURANCE COMPANY OR YOU HAVE AN ATTORNEY REPRESENTING YOUR CASE; WE REQUIRE ADDITIONAL PAPERWORK PRIOR TO TREATMENT. PLEASE ASK RECEPTIONIST).**

Printed Name of Patient or Guardian: _____

Signature of Patient or Guardian: _____Date:_____

WSFA Staff Signature: _____ Date: _____

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office'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 expected 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 the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below 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 massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate 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 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 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.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

PATIENT NAME:

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE: **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the healthcare provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the healthcare provider and/or other licensed healthcare providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the healthcare provider, including those working at the healthcare provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the healthcare provider, and/or the healthcare provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) and provide National Arbitration and Mediation ("NAM") with the party arbitrator's contact information within thirty days of the date Respondent files its initial responsive pleading. A third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties from a list of arbitrators supplied by National Arbitration and Mediation ("NAM") within thirty days thereafter. The list supplied by NAM shall be a list of between 5 and 10 arbitrators, depending upon availability. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's equal share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that, where not in conflict with this agreement, the Healthcare Malpractice Dispute Resolution Rules and Procedures of NAM shall govern any arbitration conducted pursuant to this Arbitration Agreement. A copy of NAM rules are available on its website at https://www.namadr.com or by calling 1-800-358-2550 to request a copy of the rules.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the healthcare provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient Name (print): _____ Signature: _____ Date: _____

Parent or Guardian (print): _____ Signature: _____ Date: _____

Office Name: _____ Signature: _____ Date: _____

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

Westside Family Acupuncture Inc.
5115 Coors Blvd. Ste. E Albuquerque, NM 87120
505-897-6560 / Fax 505-715-5537
www.abqacu.com / abqacu@gmail.com

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practice provides information about how we may use or disclose Protected Health Information (PHI) about you (the patient). This notice contains a patients' rights section describing your rights under the law. You establish by your signature you have reviewed our notice before signing this consent.

Protected health information may be disclosed or used for medical treatment or consultation, billing or claims payment, healthcare operations, or other providers relevant to your care.

Westside Family Acupuncture stipulates the rendering of treatment will be pending upon execution of this HIPAA Consent form. No insurance can be billed on the patients' behalf without this signed HIPAA consent form. Payment in full is required at the time services are rendered for self pay (TOS) patients.

Westside Family Acupuncture reserves the right to change the privacy policy as allowed by law. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to restrict the use of your information; however, Westside Family Acupuncture does not have to agree to those restrictions. You have the right to revoke this Consent in writing, signed by you; however, such a revocation will not be retroactive.

May we discuss your medical condition with a family member/guardian/caretaker? _____YES _____NO
If YES, please name the family member/guardian/caretaker allowed:

(List name(s) _____

By signing this form, you consent to our use and disclosure of your PHI and potentially anonymous usage by our doctors in publications. WSFA provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Signature: _____Date:_____

Consent signed by (printed); _____

Relationship to patient (if other than patient) _____

WSFA Staff Signature:_____Date:_____