



NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

- We keep a record of the health care services we provide you.
- You may ask to see and copy that record.
- You may also ask to correct that record.
- We will not disclose your record to others unless you direct us to do so, or unless the law authorizes or compels us to do so.
- You may see your record or get more information about it by contacting the Office Manager / HIPAA Officer.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

Your signature below is acknowledgment that you have been provided with a copy of our Notice of Privacy Practices to read.

Patient or legally authorized individual signature

Date Time

Printed name and signed on behalf of the patient

Relationship
Parent, legal guardian, representative.

Witness/Staff Member

(Notation, if any, by staff)

This form will be retained in your medical record.



Clinic Financial and Cancellation Policy

Dear Patient,

We know your health is important and will do everything we can to help you feel better as quickly as possible. We consider our relationship with you to be a partnership where we will monitor, guide and direct you through each step of the process while you follow-through with the recommendations provided. This journey will take time and require both of us to fully participate in your healing process.

I would like to introduce you to our office policies. Please read and sign below that you understand the clinic's guidelines. Please feel free to ask any questions you have regarding these policies.

SCHEDULING POLICY

We have set up a specific course of treatment for you. A certain number of treatments in a set amount of time are required for us to get the results we both desire. Thus, we ask that you follow the guidelines below:

- 1. If you need to change the time of your appointment, please reschedule for another time on the same day.**
- 2. If the same day is not possible, be sure to make up the missed appointment within 7 days.**

CANCELLATION POLICY

When you schedule your appointment, this time is reserved specifically for you to receive undivided attention and care with your practitioner.

In the event that you must cancel your scheduled appointment, please give us the courtesy of as much notice as you possibly can. Due to the nature of this practice and the limitation of available appointment slots, a charge will be incurred if you are unable to **give at least 24 hours notice of cancellation for your reserved time**. If there is an available slot open on the same day and time that you can make, then a cancel fee will not be applied.

It is understandable that an unforeseeable instance may make it impossible for you to keep your appointment, as a courtesy we have the following cancellation fees:

***First missed appointment: 50% of the FULL FEE will be due.**

****Subsequent misses/ late cancellations: 100% of the FULL FEE will be due**

In preventing this fee charge, **please call the office immediately** to cancel your appointment and we can reschedule. **Please do not email** as I am less likely to receive your notice in a timely manner.

ARRIVING LATE POLICY

If you are going to be late, please call the office and let me know and I will wait until the time we agree upon. If you do not give notice, I will wait 15 minutes beyond the start time of your appointment. If you have not arrived by then your appointment will be cancelled and you will be responsible for the **50% full fee** payment.

PAYMENTS

Payments are due at the time of service and paid in full. MasterCard, Visa, cash, and checks. If you pay by check and it is returned from your bank, a \$30 fee as "return check" will be added to your bill.

PHONE CALLS

Please feel free to phone when necessary and I will respond as soon as possible, or within 24 hours. However, I am unavailable on weekends.

Thank you for your attention to these important matters.

Signature: _____ **Date:** _____

Printed Name: _____

Consent to Treatment Form

By signing below, I do hereby request and voluntarily consent to methods of treatment used in this practice may include, but are not limited to acupuncture, Chinese herbs, moxibustion, cupping, electrical stimulation, gua sha, heat therapy, ear seeds, massage, nutritional therapy and supplements, lifestyle counseling, and other any other holistic modalities by a licensed acupuncturist at the *Vibrant Life Acupuncture & Integrative Medicine* clinic. I understand that acupuncturists practicing in the state of North Carolina 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.

I understand that acupuncture, moxibustion, electrical stimulation, cupping, gua sha and pricking are all safe methods of treatment. I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) 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. Potential risks include local bruising, swelling, minor bleeding, pain or discomfort, numbness and tingling, and soreness at the needling site that may last a few days. Very unusual risks of acupuncture include dizziness, fainting, nerve damage, pneumothorax, and the possible aggravation of symptoms existing prior to acupuncture treatment. There is always a risk of infection even though the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential but unlikely risks of moxibustion are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments. I also understand that certain social habits and medications may decrease the beneficial effects of Chinese medical treatment. These include the use and abuse of alcohol, pain killers, steroids, narcotics, tobacco, anti-depressants, and illegal drugs. I understand that I may refuse any of these treatments at any time.

I understand that substances like Chinese herbs or nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses and may be prescribed to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call Vibrant Life Acupuncture & Integrative Medicine immediately.*

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid specific acupuncture points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment; payment and healthcare operations received, incurred or carried out at this practice. I also certify that I have informed my acupuncturist of all known physical, mental and medical conditions and medications, and I will keep her updated on any changes. 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.

Signature: _____

Date: _____

Printed Name: _____

Date of Birth: _____

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.

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, 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 health care 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 health care provider and/or other licensed health care providers or preceptorship 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 health care provider, including those working at the health care 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 health care provider, and/or the health care 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.

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) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata 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 damage 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 the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

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 health care 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 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.

PATIENT SIGNATURE	X	(Date)
(Or Patient Representative)		(Indicate relationship if signing for patient)
OFFICE SIGNATURE	X	(Date)

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

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 recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided)

**Initial
Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. _____

- I understand that I am opting for an elective treatment that may not be urgent or medically necessary. I understand there are alternatives to receiving this care, which could including receiving care from another type of provider, or postponing care altogether at this time. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____

- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. _____

- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:

*Fever	*Dry Cough	*Sore Throat
*Shortness of Breath	*Runny Nose	*Loss of Taste or Smell

- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. _____

- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____

- I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient Signature: _____	Parent / Guardian Signature _____	Witness Signature _____
Name _____	Name _____	Name: _____
Date _____	Date _____	Date: _____