Star City Acupuncture, PLLC. Bobbi Jo Epperson; L.Ac.
Licensed in Washington State, # AC60499458

ACUPUNCTURE INFORMED CONSENT TO TREAT

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 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 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 spontaneous miscarriage, 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. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

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 results are not guaranteed.

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.

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 condition(s) for which I seek treatment.

Signed_____**Dated**_____

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

Please see reverse side for Office Policy information

Star City Acupuncture Office Policies

1. Cancellation/Missed Appointment Policy

I require 24 hours notice for cancelled appointments. Any cancellation with less than 24 hours notice or a missed appointment will be subject to a $65 time of service fee. Practitioner reserves the right to terminate treatment after three no-shows by the patient.

Please initial here _____to confirm that you understand and agree to honor this policy.

2. Payment Method

I accept payment by cash, check, or credit card. There is a $20.00 fee for a bounced check and only one occurrence is permitted. If a second check bounces, I will accept cash-only payment from then on.

C. Electronic Communications Consent

The most secure, HIPPA compliant method of communicating with you is by telephone. You may need or want to communicate by email or through text messaging. Due to the HIPPA Privacy and Security Rules, your permission to communicate with you through email/texting is requested.

I confirm that I wish to communicate with Star City Acupuncture by email/text messaging and I understand that:

- Email/Text communication will be considered and treated with the same degree of privacy and confidentiality as written medical records.
- Standard email communication services, such as AOL, Yahoo and Hot Mail are not secure. This means that the email messages are not encrypted and can be potentially intercepted and read by unauthorized individuals.
- Your email address will not be used for external marketing purposes without your permission.
- Text Messaging is not a totally secure system for sending and receiving information.

I have read and understood the above description of the risks and responsibilities associated with electronic communication with Star City Acupuncture.

I acknowledge that commonly used email services are not secure and fall outside of the security requirements set forth by the Health Insurance Portability and Accountability Act for the transmission of protected health information. I have been given the opportunity to discuss electronic communication with Star City Acupuncture and have had all my questions answered. In consideration for my desire to use electronic communication as an adjunct to in-person office visits, I herby consent to electronic communication via non-secure email services and text messaging. I understand that I may revoke my consent to communicate electronically at any time by notifying the practice in writing at the address above, but if I do, the revocation will not have an affect on actions my healthcare provider or team has already taken in reliance on my consent.

I agree and release Star City Acupuncture from any and all liability that may occur due to electronic communication over a non-secure network. I further agree to be held accountable and to comply with the patient responsibilities as outlined in this consent.

PATIENT

_____ Patient Name (Print)

_____ Patient Signature Date