Consent for Acupuncture Treatment & Associated Therapies

I, the undersigned, authorize the nationally certified and Oregon state licensed acupuncturist, Kenneth Glowacki to perform the following procedures:

- **Acupuncture:** The insertion of pre-sterilized, disposable needles through the skin into the underlying tissues at specific points on the surface of the body.
- **Fascial Counterstrain:** an osteopathic therapy which aims at releasing constrained body-wide fascial tissue and circulatory blockages
- **Tuina & Acupressure:** Traditional Chinese medical massage and manual therapy.
- **Sound Therapy:** The use of singing bowls, tuning forks, gongs and other sound instruments.
- **Electroacupuncture:** Using very small amounts of electricity to stimulate specific acupuncture points.
- **Infrared Heat:** Applying heat generated by an infrared lamp over a specific area of the body.
- **Cupping:** Glass cups are placed on the skin with a vacuum created by heat or suction device.
- **Gua Sha:** a rubbing technique on an area of the body with a round instrument.
- **Moxa:** an indirect warming technique on an acupuncture point using an herbal stick, string or ball moxa to relieve symptoms.
- **Liniments, Essential Oils, Plasters, Tapes**: Herbal formulas applied topically to the skin.
- **Herbal Consultations:** as dietary advice based on the Traditional Chinese Medical Theory.

I recognize the potential risk and benefits of these procedures as described below.

- **Potential Risk:** discomfort, pain, infection, and blistering at the site of procedure, temporary discoloration of the skin, and even aggravation of symptoms existing prior to the acupuncture treatment.
- **Potential Benefits:** drugless relief of presenting symptoms and improved balance of bodily energies, which may lead to prevention, or elimination of presenting health problems.

I understand that I need to notify the acupuncturist if I have a pacemaker, a bleeding disorder, or if I am pregnant or plan to become pregnant.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me regarding cure or improvement of my condition. I hereby release Kenneth Glowacki, L.Ac., from any and all liability, which may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw consent and to discontinue participation in these procedures at any time.

Signature of Patient_____ Date_____

Or of person authorized to consent_____ Date_____

With my signature, I acknowledge that I have read the above statement and agree to pay the full office charge for appointments cancelled or broken without 24 hours advance notice. Under limited circumstances, I also understand that my insurance will be billed as a courtesy, if I so request, but any balance is due and payable by me. I authorize Kenneth Glowacki, L.Ac. to release any information required to process my claims and authorize my insurance company to make payment directly to my provider.

Signature of Patient_____ Date_____

Consent for Acupuncture Treatment & Associated Therapies

NOTICE OF PRIVACY POLICIES

Our office, Art of Acupuncture, LLC, is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and health information in several ways;

- Information we receive.
- Information we receive from other healthcare providers.
- Information we receive from third party payers.

This information is used for treatment, payment and healthcare operations.
You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for the treatment, payment, and healthcare operations.
You may specifically authorize us to use protected health information for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have your protected health information.

Marketing

This office will not use your health information for marketing communications without your written authorization. This office may send birthday cards, newsletters and appointment reminder, by calls, post cards or letters.

Disclosure

This office may use or disclose your Protected Health Information when required by law.

Patient Rights

1. Upon written request you have the right to access, review or receive copies of your healthcare records.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
4. You have the right to request that we amend your Protected Health Information; the request must be in writing.
5. You have a right to receive all notices in writing.

If you have questions, complaints or want more information contact this office.
Kenneth Glowacki, L.Ac.
8216 SW 42nd Ave., Portland, OR 97219, (503)707-2702

Send a written complaint to the U.S. Department of Health and Human Services.
DHHS (Office of Civil Rights)
200 Independence Ave S.W. Room 509 F HHH Building
Washington, DC 20201

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have read, reviewed, understand and agree to the statement of the Privacy Policy for healthcare services in this office, Art of Acupuncture, LLC.

This practice provides each patient with a statement of Privacy Policies.

Patient's Signature :

Date :