CONSENT FOR EXAMINATION AND TREATMENT

I acknowledge that during the course of my care I (or the person named below for whom I am legally responsible) may receive acupuncture and other oriental medicine procedures.

I understand that, as in the practice of medicine, in the practice of other clinical therapies there are some risks to treatment. I understand that if acupuncture and oriental medicine treatments the risks include but are not limited to: minor bleeding, local bruising, fainting, burning, pneumothorax, miscarriage, temporary pain, and discomfort and the possible temporary aggravation of prior existing symptoms.

I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on her to exercise judgment during the course of the procedure which he or she feels at the time, based on the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. By signing below I agree to the above named procedures. 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.

_____

Patient's name (Please Print)

_____ _____

Signature of patient **Date**
(or guardian if patient is a minor)

HIPPA Compliance Requirement

Patient Consent to the Use/Disclosure of Patient History Information
for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Elisa K. Wong L.Ac. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

A basis for planning my care and treatment,
A means of communication among the health professionals who contribute to my care,
A source of information for applying my diagnosis and treatment to my bill,
A means by which a third party payer can verify services billed were actually provided,
A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity and I consent to such disclosure for these permitted uses, including disclosures via fax. A copy of the Notice of Information Practices is available upon request.

_____

Print Name of Patient

_____ _____

Signature of Patient **Date**

_____ _____

Authorized Facility Signature **Date**