Patient Name:_____ Date: _____

HIPPA PRIVACY NOTICE

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully. We at OM.YASI Acuhealing pledge to give you the highest quality health care and our commitment to respect the privacy and confidentiality of your health information. This notice is being given to you because federal law gives you the right to be told ahead of time about how we handle your health information, your rights regarding your health information and how you exercise them, our duties concerning your health information and how to complain if you believe your privacy rights have been violated.

HOW WE HANDLE YOUR HEALTH INFORMATION

Health information means information you give about yourself and your health when you become our patient. This information is stored in your chart and in electronic form on the computer. We use your health information within our office and may in some cases share it with others outside our office, in order to give you excellent care. We may legally use and share your health information, without asking for your specific permission, for:

Treatment – This means how we provide and manage your health care and related services, and might include coordination of your care with other providers, to ensure that everyone caring for you has the information they need where applicable.

Payment – This means sharing your health information in order to bill and collect payment for health services we give you, where applicable.

Health Care Operations – These are activities related to the business aspects of operating OM.YASI Acuhealing and carrying out our mission and could include storing your information on computers, conducting quality assessment and improvement activities, auditing and financial recordkeeping. Other purposes including complying with state and federal laws and regulations, required reporting to public health and child protection authorities, for legal and administrative proceedings, law enforcement purposes, to avert a serious threat to health or safety, and other permissible purposes. All those we may share information with must also take steps to keep our health information private. We will disclose only the minimum amount of information necessary to achieve the required purpose. We will utilize physical safeguards for your information including shredding of personal documents not in use and retaining records in a secure location. We will train all our staff to comply with this notice and our privacy practices. We may use your health information to contact you. Address and telephone numbers given to us will be used as needed to inform you of scheduled or cancelled appointments, billing or payment matters, procedure assessments, and test results. We may also contact you concerning care issues, treatment choices, follow-up care instructions, and other health related benefits and services that we feel may be of interest to you. If you cannot be reached we will leave a voice message if necessary.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION AND HOW TO EXERCISE THEM

You have the right to ask for restrictions on the use and sharing of your health information for treatment, payment or health care operations including restrictions on using this information to contact you directly. For example, you may ask that we not contact you with appointment reminders, or that we only call your cell phone number rather than home number. When we ask you to provide us with information necessary for contacting you, it is your responsibility to make sure the information is accurate and current. We are not required to agree to your request for restrictions, but will make reasonable efforts to honor all requests.

Patient Name:_____ Date: _____

HIPPA PRIVACY NOTICE
(Continuation)

You may not ask us to restrict uses and sharing of information that we are legally obligated to. You have the right to look at and get a copy of the health information that we keep in your medical treatment and bills. You must ask for this in writing and allow up to thirty (30) days for processing. If you ask for a copy of records you will be charged and copy fee. If we deny your request, we will explain the reasons in writing and tell you what rights you have, if any, to a review of the denial. You have the right to ask us to change your health information relating to your treatment and bills if you think there has been a mistake or information is missing. You must make this request in writing and give the reason you want the change. We will have sixty (60) days to respond to your request, and a thirty (30) day extension after with notice of why we need the extension and when you may expect a response. We may deny your request, and if so, must provide you with a written statement entailing the reasons for the denial and what other steps are available to you.

You have the right to get a record of the times that your health information was shared, except when the sharing was for treatment, payment, health care operations, or if you gave permission, or when the law requires us to share the information. You must request the records in writing and the list will include the date, name, address, a brief description of the information given, and a statement of why the information was shared. We will have sixty (60) days to respond to your request, and a thirty (30) day extension after with notice of why we need the extension and when you may expect a response. You are entitled to one free request in any twelve (12) month period.

OUR DUTIES CONCERNING YOUR HEALTH INFORMATION

We are required by law to keep your health information private. We are required by law to keep your health information private. We are required to give people notice of our legal duties and privacy practices concerning your health information. We must abide by the terms of the notice currently in effect. We reserve the right to change our privacy practices and the terms of this notice at any time. If so, the notice will be posted in our office for public inspection.

HOW TO COMPLAIN IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED

If you think we may have violated your privacy rights or you disagree with any action we have taken with regard to your health information we want you, your family, or your guardian to speak with us. If you complain to us, your care will not be affected in any way. It is our goal to give you the best care while respecting your privacy. You may file a complaint by contacting any member of our staff at 7800 SW 57 Ave, Suite 203, Miami, FL 33143. You may also send a written complaint to the U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201 or call 202-619-0257, or toll free 1-877-696-6775. We will take no retaliatory actions against you if you file a complaint about our privacy practices.

EFFECTIVE DATE OF THIS NOTICE: SEPTEMBER 1, 2013

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing below, I acknowledge that I have been given a copy of this privacy notice and have been given an opportunity to review it and ask any questions I may have about it and what it means to me.

_____ _____

Patient or Representative Signature Date

Patient Name:_____ Date: _____

INFORMED CONSENT FOR ACUPUNCTURE

Acupuncture is considered a safe method of treatment but every procedure involves a certain amount of risk and it is important that you understand the risks involved with an acupuncture treatment. Although the majority of patients do not experience the following complications, you should make sure you understand the risks, potential complications, and consequences of acupuncture.

Herbs and nutritional supplements may be recommended and are considered safe in the practice of Chinese Medicine.

It is important that you read the information carefully and have all of your questions answered before signing the consent on the next page.

Acupuncture: 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. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. 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 effect 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 the Radiant Source Acupuncture and Herbs as soon as possible.*

Moxibustion/TDP lamps: I understand that heat treatments with Moxa & TDP lamps are methods used to warm areas of the body to promote health. I am aware that every precaution is taken to prevent over-warming, but the rare possibilities of mild burns exist. I understand that I may refuse this treatment.

Cupping: I understand that cupping is a technique that involves localized suction produce by heating a small glass cup. I am aware there is a possibility of local non-painful bruising from the suction. Very rarely a slight burn or blister may appear due to the heat. I understand that I may refuse this treatment.

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Patient Name:_____ Date: _____

INFORMED CONSENT FOR ACUPUNCTURE
(Continuation)

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

Contraindications for acupuncture or use of Chinese herbal medicine: Contraindications for acupuncture and certain herbs include a history of a bleeding disorder or current anticoagulant therapy, an implanted pacemaker or prosthetic heart valve, use of certain medications and/or pregnancy.

I do not have an implanted pacemaker or prosthetic heart valve. I do not take steroids or anticoagulants. I take the following drugs: _____

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. No guarantee of results has been made.

_____ _____
Patient or Authorized Guardian Signature Yasibit Teran, DOM, AP

_____ _____
Date Date

Patient Name:_____ Date: _____

CONSENT FOR ACUPUNCTURE PROCEDURE OR TREATMENT

1. I hereby authorize Yasibit Teran to perform acupuncture treatment. I have received the following informed consent form:

INFORMED CONSENT FOR ACUPUNCTURE

2. I recognize that during the course of acupuncture treatment, unforeseen conditions may necessitate alternative procedures or methods of treatment. I therefore authorize the above acupuncturist to perform such other procedures that are in the exercise of his or her professional judgment necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my acupuncturist at the time the procedure is begun.

3. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.

4. It has been explained to me in a way that I understand:
   a. The treatment or exposure to be undertaken
   b. There may be alternative procedures or methods of treatment
   c. There are risks to the procedure or treatment proposed

I consent to the treatment or procedure and the above listed items.
I am satisfied with the explanation.

_____ _____
Patient or Authorized Guardian Signature Yasibit Teran, DOM, AP

_____ _____
Date Date

Patient Name:_____ Date: _____

FINANCIAL AND CANCELATION POLICY

OM.YASI Acuhealing practitioners request payment for your treatment at the time of service. Cash and Credit Cards are accepted.

Yasibit Teran is a provider with most of the major insurance companies, and she will submit the claims directly for those insurers only.

If your visit will not be covered by an insurance plan, or if you fail to provide proof of insurance, payment in full is expected at each visit. We will verify your insurance coverage as a courtesy, but knowing your insurance benefits is your responsibility, so please contact your insurance company with any questions you may have regarding your coverage. Initial _____

Co-Payments and Deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. In the event we bill your insurance carrier and the claim is returned to us because the deductible has not been satisfied, we will bill you for those services. Please understand that it could take several months between the time of service and the issuing of our billing statement once we receive notification from your insurance carrier regarding your deductible balance. Initial_____

Non-Covered Services. Please be aware that some, and perhaps all, of the services you receive may not be covered or considered reasonable or customary by Medicare and other insurance carriers. These services must be paid for at the time of your visit. In the event we bill your insurance carrier and the claim is returned to us because the services are not covered, we will bill you for the non-covered services. In addition, supplements and herbal medicine is not covered by your insurance plan.
Initial _____

Insurance Claim Submission. Your insurance company may on occasion ask you to provide them with additional information. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. Initial _____

Nonpayment. If your account is over 90 days past due from our first billing sent to you, it will be referred to a collection agency for payment. By signing this agreement you will also authorize the office to release information needed to secure payment. Initial _____

Missed Appointments. If you miss your appointment or cancel with less than 24 hours' notice, you will be charged a fee of $25.00. Initial _____

I have read and understand the policies and agree to abide by the guidelines.

_____ _____

Patient or Representative Signature Date

Patient Name:_____ Date: _____

FINANCIAL AND CANCELATION POLICY
(Continuation)

Payment is expected in full at time of service unless other arrangements have been made with the office. The patient will be expected to pay all charges in full at the time of each office visit. We accept cash and credit cards

If you find that you are unable to make it to your appointment and need to cancel or reschedule, we ask that you give no less than 24-hour advance notice. Accordingly, you will be charged a fee of $25.00 if you give less than the required 24-hour notice. Please note that if you are more than 15 minutes late for your appointment, you will have to reschedule and the cancellation policy will apply. We do understand that emergencies arise and will consider these on a case-by-case basis.

CHART OF FEES:

DESCRIPTION OF SERVICE	COST PER SESSION
First Time Visit/Acupuncture Treatment	$100
Follow Up Acupuncture Treatment	$75
Herbal Supplements	Varies

In an effort to make care more accessible and affordable to our patients, we also offer two packages at a discounted rate. The more sessions you book, the greater the savings. Please inquire about payment plans.

NUMBER OF SESSION	DESCRIPTION OF SERVICE	COST PER SESSION
6	Acupuncture	$65
12	Acupuncture	$60

More and more insurance companies are covering acupuncture treatments. If you have insurance that covers acupuncture, we will gladly provide an itemized bill for you which will include all procedure codes required for filing a claim. You are responsible for submitting this to your insurance company and may request a reimbursement directly to you. Unless prior arrangements are made, payment is expected from you at the time of service in the form of cash and credit cards.

Herbal supplements and missed appointment fees are not covered by insurance.

By signing this form you indicate that you have read, understand, and accept these policies.

_____ _____
Patient or Representative Signature Date