Arcadia Women's Wellness

body | mind | chi

CONSENT AND UNDERSTANDING

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

Consent Related to Privacy Notice: I have had a chance to review the Practice Privacy Notice as part of this registration process (available online). I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

Consent for Care: I, with my signature, authorize Dr. Leigh Lewis to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Informed Consent for Acupuncture Treatment

I hereby agree and consent to the performance of acupuncture and other traditional ChineseMedicine procedures. I understand that such procedures may include, but are not limited to acupuncture, acupressure, moxibustion, cupping & gua-sha (dermal friction technique), infrared heat lamp, breathing techniques, exercise therapy, based on traditional Chinese medical theory. Occasionally, there may be increased soreness at the sites of treatment on the day of, or day following treatment. I have been informed that in all acupuncture treatments only sterile, disposable needles are used according to the Clean Needle Technique protocol, to ensure the safest acupuncture treatment possible. I have been informed that acupuncture is a safe method of treatment, but may have some side effects, including bruising, numbness or tingling, dizziness or fainting, minor swelling, bleeding, hematoma may occur at the site of insertion and may last a few days. A sensation of light-headedness may occur after acupuncture treatment. I will immediately notify the acupuncturist if I experience any symptoms or problems. I understand that I should not make significant movements while the needles are being inserted, manipulated, retained, or removed. I am relying on the TCM practitioner to exercise judgment during the course of my treatment, trusting that, based upon facts then known, this treatment plan is appropriate and in my best interests. I understand that acupuncture and other Oriental Medicine procedures are not substitutes for treatment by my medical doctor. Also, at any given time throughout the treatment, I may request the practitioner to stop, modify or change the treatment plan. I state that I do not have the following conditions or will inform the provider if I develop such condition: pregnancy, bleeding disorders, pacemaker, local infections; or am currently taking anticoagulants.

Cancellation Policy:

All appointments must be cancelled 24 hours in advance.
If sufficient notice is not given to the clinic, a fee equal to $35 may be charged.

Refund Policy:

There is no expiry date on purchased service packages. Service packages may be transferred or shared with another individual, if approved in advance by provider. As service packages are discounted per treatment, there is no refund on service packages.

CONSENT AND UNDERSTANDING (continued)

Financial Policy

I understand that all fees are due at the time of service and that my contract with my insurance entity may or may not cover some services. All insurance policies are not the same. They vary by employer group. Arcadia Women's Wellness is not responsible or able to know every policy available, but will provide documentation to submit for reimbursement when asked to do so.. It is my responsibility to verify applicable coverage prior to receiving the services. For example, not all health plans include screenings as a benefit. If I seek care outside of the contract terms, I am aware that I may be responsible for all charges that are incurred.

Thank you for your understanding and cooperation with this policy. It is our privilege to provide your medical care.

I have read and understand the Consents and Financial Policy stated above and agree to accept full responsibility as described above and have had an opportunity to ask questions and that I consent to treatment with the modalities described above. I intend this consent form to cover the entire course of treatment to be performed for my present condition and for any future condition(s) for which I seek treatment.

Print Name of Patient _____

Signature of Patient _____

Date: _____