Jennifer A Moore L.Ac.
541.910.2046

Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist at the Chinese Medical Clinic. I understand that acupuncturists practicing in the state of Oregon are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

Acupuncture/Moxibustion: 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.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

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 Jennifer as soon as possible*.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

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.

Signature: _____Date: _____

Printed Name: _____

Jennifer A Moore, L.Ac.
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Patient Information

Name_____
Address_____
Home Phone_____work_____cell_____
Which phone is best?_____
Is it ok to leave a message at this number?_____
Emergency Contact phone_____
How did you hear about this service?_____
Name and address of your physician_____
Reason for your last visit with physician_____date_____
Please list all of your current medications/supplements, including dosage:

_____
_____
_____
_____
_____

If you have insurance, please fill out the following page.

Payment Policy

The Cash price for treatment is 125$ for the intake and first treatment, which is approximately 1 hour and 45 minutes, and 75$ thereafter for a 45 minute treatment, paid at the time of the treatment. The cost of herbs is paid separately. 24 hour advance notice is required to cancel an appointment, and if it is not given, full price will be charged for the appointment. Please sign and date below to indicate that you have read and accept this policy.

Signed_____date_____

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Insurance Information
Name_____
Date of birth_____
Insurance information:
Company name & phone:_____
Primary insured's name and date of birth:
_____

Policy #_____ group #_____
By signing below, you are giving me permission to bill your insurance provider for you.

Payment Policy
Insurance will be billed at a rate of approximately $165 for the initial visit and first treatment, and approximatley $110 for treatments thereafter. By signing below, you are agreeing to pay your portion of this cost. The cost of herbs is paid separately. 24 hour advance notice is required to cancel an appointment, and if it is not given, full price will be charged for the appointment. Please sign and date below to indicate that you have read and accept this policy.

Signed_____date_____

Jennifer A Moore, L.Ac.
207 Fir
La Grande, OR 97850

541.910.2046

Our Clinic Protects Your Health Information and Privacy (HIPAA STATEMENT)

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company¸ with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at our office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include nonpublic
personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (*e.g.* requests for medical records, claim payment information).

I value our relationship, and respect your right to privacy.

Jennifer A Moore L.Ac.
541.910.2046

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME _____

I understand that as part of my healthcare, or my legal dependent's healthcare, this organization originates and maintains health records describing health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

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

I understand that I have the right:

- To object to the use of health information for directory purposes.
- To request restrictions as to how this health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

Patient:

X_____ _____ _____

Patient Signature or Legal Representative Date Witness Signature