Windhorse Medicine
512.917.3404
1210 Rosewood Avenue, Austin, Tx, 78702
www.windhorsemedicine.com

Patient Name (please print) _____Date_____

NOTIFICATION FORM REGARDING EVALUATION OF PATIENT BY PHYSICIAN

(Pursuant to the requirements of 22 T.A.C. §183.7 of the Texas State Board of Acupuncture Examiners' rules)

I am notifying Windhorse Medicine of one or more of the following:

☐ I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

☐ I have received a referral from my chiropractor within the last 30 days for acupuncture. After being referred by a chiropractor, if after two months or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

☐ I am seeking acupuncture and Oriental Medicine for one or more of the following: chronic pain, weight loss, smoking or drug addiction cessation.

PRIVACY NOTICES

Consent for Purposes of Treatment, Payment, and Healthcare Operations...I understand I have a right to review the "Notice of Privacy Practices" prior to signing this document. The "Notice of Privacy Practices" describes the types of uses and disclosures of my Protected Health Information that will occur in my treatment, payment of my bills or in the performance of health care operations. "The Notice of Privacy Practices" is available upon request. This Notice of Privacy Practices also describes my rights and Windhorse Medicine's duties with respect to my Protected Health Information.

Appointment Reminders and Health Care Information Authorization...Windhorse Medicine, and other associated practitioners, may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine or with whoever answers the phone. Thank You cards, appointment reminders, birthday cards, holiday cards and other correspondence may be sent to your address. By signing this form, you are giving us authorization to contact you with these reminders and information.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have the opportunity to request a copy of this authorization.

Authorization For Release Of Health Information...Due to the Federal HIPAA Regulations enacted in April of 2003, your health care practitioners are not allowed to release any information concerning you or appointments without your written consent. Therefore, if you are interested in having someone other than yourself schedule or cancel appointments for you, pick up your herbal prescriptions, or be informed about any aspect of your treatment, you must list their names on the lines below giving us your authorization to communicate with a third party about your information. This written authorization is also necessary for insurance companies seeking knowledge about your treatments to reimburse a claim, or if you wish to have your case discussed with other doctors or practitioners outside my practice. This form is included in your initial paperwork on your first visit. Please know my authorization to communicate about your treatment is limited only to those people you have listed on this form. We cannot release any information to anyone not listed on your medical records release form. If, at any time, you need to add to or amend this form please see a front desk receptionist.

I hereby authorize Windhorse Medicine, and other associated practitioners the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/Organizations receiving the information: (please print)

_____

_____

Patient Signature_____

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Patient Name (please print) _____Date_____

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that method of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Oriental Massage), Oriental herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effect associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness, or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping or gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is anther possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts they know is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.

APPOINTMENTS

I charge the full fee for "no show" appointments. An appointment is considered a "no show" if: (1) There is less than twenty-four hours notice for cancellation (2) Arriving 20 minutes late without phone notification

☐ Please charge the fee for my missed or late cancellation appointment to my credit card.

Card type: _____ Name on the card:_____Card #: _____exp. Date:_____/_____

OR

☐ Please invoice me to the following address:

_____ _____

PAYMENT FOR SERVICES RENDERED

Payment is due at the time of service and may be paid in cash, check, or credit card.

INSURANCE

I do not file insurance claims of any kind. Upon request, I will provide you with a printed receipt.

Patient Signature_____