Acupuncture
1761 Ogden St. Denver, Co 80218

First Patient: Prior to Treatment Forms

Hello and welcome to Yin Fire Acupuncture!

OFFICE and FINANCIAL POLICIES

****Please read the following forms carefully. Sign and date each form prior to treatment**

Fee Schedule:
• 90 minute treatment: $ 85 + cost of herbs
• 60 minute treatment: $65 + cost of herbs
• 30 minute treatment: $35 + cost of herbs

Financial Policies:
- Your payment is due in full at the time of service.
- For your convenience, we accept cash, check or credit cards.
- For checks returned to us as unpaid by your bank, you will be charged a $25 fee.

Minors:
- All minors must be accompanied by an adult or legal guardian at all times during the treatment.

Cancellations & missed appointments:
- Please provide 24-hour notice of cancellation prior to your scheduled appointment.
- If you miss an appointment or cancel less than 24 hours in advance, you may be subject to a $35 fee.

Reasons for being dismissed/denied treatment:
- Patients who show inappropriate conduct
- Late -or- nonpayment of fees
- Patients who exhibit safety concerns towards themselves or anyone else

I have carefully read and understood 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.

Patient or Parent/Legal Guardian name: _____ Date:_____

Signature: _____

Email: tsf@yinfire.com
Phone: 720-432-7634
Web: www.yinfire.com

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NOTICE OF PRIVACY/HIPAA PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. The privacy of your health information is important to Yin Fire Acupuncture LLC and all the employees working for Yin Fire Acupuncture LLC.

Uses and Disclosures of Health Information:

- Treatment: Your health information may be disclosed for treatment or to a physician or other health care provider providing treatment to you.
- Payment: Disclosure of your health information may be used to obtain payment for services we provide to you. It may also be disclosed to another health care provider or entity that is subject to the Federal Privacy Rules for its payment activities.
- Health Care Operations: Disclosure your health information may be used for our health care operations including: quality assessment and improvement activities, reviewing competence of healthcare professionals, evaluating practitioner/provider relationships, conducting training programs, accreditation, certification, and credentialing or licensing activities. Disclosure of your information to another healthcare provider or organization that is subject to the Federal Privacy Rules and that has a relationship with you may be to support some of their health care operations.
- You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.
- On Your Authorization: You may give us written authorization to use your health care information or disclose it to anyone for any purpose. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.
- Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help you with your health care or with payment for your health care. Before we disclose your health information, we will provide you with an opportunity to object to our use or disclosure. If you are not present or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We will also use our experience and professional judgment to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, or similar forms of health information.
- Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit: • As required by law

• For public health activities: reporting disease/statistic, child abuse, work-related illness/injury

• To report abuse, neglect, or domestic violence in response to court/administrative orders and other lawful processes

You Have the Right To:

- Request a copy of our Privacy Practices Notice at any time
- Look at and obtain a copy of your health information
- Deny courtesy calls, emails, or letters sent by our office
- Request a restriction on certain uses and disclosures of your health care information
- Receive confidential communications regarding your health information
- Revoke any authorizations that you made previously in regard to your protected health information

Our Responsibilities:

- Maintain the privacy of your health information as required by federal and state law
- Maintain the privacy of your health information as required by federal and state law
- Provide you with a notice of our Duties and Privacy Practice
- Abide by the terms of this notice

***I have carefully read and understood 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.*

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Signature: _____

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INFORMED CONSENT

I hereby voluntarily request and consent to be treated, or give permission for my child/minor to be treated, with acupuncture and other techniques based on Traditional Asian Medicine. I understand I may be given diet/lifestyle recommendations and/or nutritional or herbal supplements and that it is my decision whether or not to follow these recommendations. The procedures involved in this treatment have been explained to me. I have not been guaranteed any success concerning the uses and effects of these treatments. I understand that I am free to discontinue treatment at any time.

• Possible Side Effects/Healing Reactions:

I understand that these treatments may result in certain side effects, including local bruising, slight bleeding, fainting, temporary pain or discomfort, and temporary aggravation of symptoms existing prior to treatment. Unusual and rare risks of acupuncture include nerve damage, organ puncture, and infection. I have read the information on this page and understand the possible risk involved. By signing below, I do hereby voluntarily consent to be treated with Acupuncture and/or any modality under this scope of practice.

- **Acupuncture:**

I understand that acupuncture is performed by the insertion of sterile needles through the skin with or without electrical stimulation which produces a vibration/tapping sensation on the needles or by the application of heat to the skin (or body) at certain point 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 occur. These could include, but are not limited to; local bruising, mild bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop treatment at any time.

- **Herbs:**

I understand that herbs, minerals, and vitamin supplements may be recommended to me to treat bodily dysfunction and diseases, to modify or prevent pain perception, and to normalize the body's physiological function. I understand that I am not required to take these substances, but must follow the directions for administration and dosages if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to; changes in bowel movements, 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 will stop taking them and contact Yin Fire Acupuncture Clinic as soon as possible.

- **Tui-na, Massage and Cupping:**

I understand that I may also be offered tui-na, massage and/or cupping therapy to modify or prevent pain perception and to normalize the body's physiological functions. I am aware the certain adverse side effects may occur. These side effects include, but are not limited to, bruising, sore or achy muscles, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too achy muscles, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable or painful. I understand that there may be other treatment alternatives, including treatment by a licensed physician.

- **Medical Referral:**

I understand that I should consult a licensed physician for appropriate medical evaluation and treatment of the conditions for which I am seeking acupuncture treatment. Treatment from this practitioner is not a substitute for appropriate medical treatment by a licensed physician. I have been advised that if there is a worsening of my ailment or condition, or if it does not improve within the time estimated by the Acupuncturist at the beginning of treatment, or if a new ailment or condition arises, I should again consult a licensed physician. If I am presently under the medical care of a physician, I have been advised to continue all medications and treatments as prescribed until such time as my physician deems it appropriate to reduce or discontinue the medications or treatments. I certify that I have informed Yin Fire Acupuncture of all known physical, mental, and medical conditions and medications, including possible pregnancy, and that I will notify Yin Fire Acupuncture of any changes.

- **Infectious Disease/Clean Needle Procedures:**

I understand that there is infectious disease carried through the air, through physical contact, and through body fluids. I understand that universally prescribed precautions will be utilized during treatments to guard against the spread of infection, including the use of sterile, prepackaged disposable needles. Needles that are used for my treatment are used only on me, and are inserted according to clean procedures based on nationally prescribed standards. Needles are disposed of as medical waste immediately after use. I understand that my questions about the safety of any procedure or treatment or the precautions taken by the practitioner are most welcome and will be answered as fully as possible. I understand I have the right to refuse any treatment or procedure. I have read this form carefully, and I have felt free to ask any questions.

I have carefully read and understood 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.

☐ By checking this box and signing below, I give my permission and consent to treatment by the practitioners of Yin Fire Acupuncture.

Patient or Parent/Legal Guardian name: _____ Date:_____

Signature: _____