Vibrant Health Acupuncture & Wellness Center LLC

Dawn R Gifford, M.Ac., L.Ac.
NADA Certified AcuDetox Specialist (ADS) #10081
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BEL AIR
260 Gateway Drive
Bel Air, MD 21014
Suite 7B

Consent to Services

Services to be Provided
Treatments include but are not limited to: *acupuncture* (insertion of sterile, disposable needles), *acupressure*, *Tuina* (Chinese massage), *Gua Sha* (rubbing of the skin with a smooth object), *cupping* (suction via application of glass cups on the skin), *moxi-bustion* (burning of mugwort herb), *electrical stimulation*, *heat lamps,* and *Chinese herbal medicine and nutritional counseling*. I understand that I may refuse any of these techniques at any time.

Risks/Possible Side Effects
Treatment may result in certain side effects, including but not limited to: local bruising, slight bleeding, dizziness, fainting, temporary pain or discomfort, burning from moxa or lamps, digestive/intestinal upset or skin irritation from herbs, temporary aggravation of symptoms existing prior to treatment, and, in very rare occasions, pneumothorax or spontaneous miscarriage. Any herbs or nutritional supplements recommended to me are from plant, animal and mineral sources and traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses.

Effectiveness & Outcomes
Acupuncture serves individuals with a wide range of complaints including both acute and chronic healthcare issues. I understand results vary for each individual, and I acknowledge that I have not received any guarantees or promises as to the results from the services to be provided.

Client Responsibilities
It is my responsibility as a client to inform my acupuncturist of: all aspects of my health; any concerns I may have before, during, or after treatments; and, as service progresses, to inform my acupuncturist of any changes that occur. I understand that some treatment methods may be inappropriate during pregnancy, so I will notify my practitioner if I am pregnant or aiming to become so or suspect pregnancy at any time.

An acupuncturist is not a substitute for a medical doctor and will not suggest the ceasing of medical treatment. It is my responsibility to consult with my doctor before altering any prescribed medications or treatments. I understand that if there is an emergency, or a worsening of my health condition, or if a new condition arises, that I should consult a licensed physician.

Payment & Cancellation Policy
I have been informed of and agree to the fees for service, and I understand that payment is due when the services are provided. If I do not cancel an appointment by phone or online message at least 24 hours in advance, then I am liable for the full amount of the missed appointment. I understand that I will pay a $50 fee for any returned checks. I also understand that repeated fiscal or other offenses (e.g., abusive behavior) by me may result in refusal of services.

I have truthfully disclosed all medical history including information regarding blood borne, contagious diseases such as hepatitis (B, C) and HIV/AIDS. _____ (your initials).

I have read (or have had read to me) and understand the information in this form, and I understand the possible risks involved. I am free to ask questions regarding this form and treatment methods at any time. I understand that I have the right to refuse or discontinue any treatment at any time. I understand such refusal may also affect expected results. I hereby voluntarily consent to be treated within the scope of practice of acupuncture by Dawn R Gifford, L.Ac., a licensed acupuncturist in the state of Maryland.

_____ _____
Patient Signature (or Parent/Guardian if client is a minor) Date

Notice of Privacy Practices

Health Insurance Portability and Accountability Act (HIPPA) requires that healthcare professionals give their clients a Notice of Privacy Practices and that clients sign in acknowledgement that they received the notice.

During your course of treatment, I will use and disclose your Protected Health Information only for treatment, payment and when required by law. Furthermore, you will be contacted when necessary using the phone number and address you have provided unless you specifically request otherwise. Upon written request:

- You have the right to review or obtain copy of your health record from me. You have the right to request that we amend your Protected Health Information.
- Your Protected Health Information is kept confidential and not shared with anyone else unless you sign a separate consent form for the release of information.
- You have the right to request additional restrictions on the use and disclosure of your Protected Health Information.

If you have any questions about your rights or believe your privacy rights have been violated, please let me know. You also have the right to file a complaint with the U.S. Secretary of Health and Human Services (Office of Civil Rights: 1-800-368-1019) with no fear of retaliation.

I acknowledge I have received and understand this Notice of Privacy Practices. _____
Patient Signature (or Parent /Guardian if client is a minor)