Woon's Healing Arts Center

253-272-9959
115 S. 8th Street
Tacoma, WA 98402

# Cancellation Policy

If you must cancel or reschedule your appointment,

a **24-hour notice** by phone call, voice mail, or email is required.

You will be charged for all missed appointments.

Reminder calls may be offered but it is your responsibility to make it to your appointment.

Initial and date

# INFORMED CONSENT

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 for 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 are not. East Asian medicine means a health care service using East Asian medicine diagnosis and treatment to promote health and treat organic or functional disorders, Christopher Woon's qualifications include the following education and license information: (a) Masters in Oriental Medicine (b) State Licenser (c) NCCOAM Certification.

I understand that methods of treatment may include, but are not limited to, acupuncture, including the use of needles or lancets to directly or indirectly stimulate acupuncture points and meridians; moxibustion, cupping, electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians; Acupressure; Dermal friction technique; Infra-red; Sonopuncture; Laserpuncture, Point injection therapy (aquapuncture); East Asian massage and Tui-Na (Oriental massage), both are a method of East Asian bodywork, characterized by the kneading, pressing, rolling, shaking, and stretching of the body and does not include spinal manipulation; Superficial heat and cold therapies; Oriental herbal medicine, Dietary advice, nutritional counseling, and health education based on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements; Breathing, relaxation, and East Asian exercise techniques; and Qi gong. 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 be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that side effects may include but are not limited to: Pain following treatments, needle sickness, broken needle, 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. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring area is 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 must inform the East Asian medicine practitioner if I have a severe bleeding disorder or pace maker prior to treatment. 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 judgement during the course of treatment, which the clinical staff thinks at the time, based upon the facts then known are 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 of my present condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE (or Patient Representative) Please indicate relationship if signing for patient DATE

# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN BET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**The Health Insurance Portability & Accountability Act of 1996 (HIPAA)** requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, to be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

**Without specific written authorization, we are permitted to use and disclose your health care records for the purposes and treatment, payment, and health care operations.**

> **Treatment** means providing, coordinating, or managing health care and related services by one or more health care provider. For example, we may need to share information with other health care providers, or specialists involved in the continuation of your care.
> **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing to collection activities, and utilization review. For example, we may disclose treatment information when billing a dental plan for your dental services.
> **Health Care Operations** include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

**Unless you request otherwise,** we may use or disclose health information to a family member, friend, personal representative, or other individual to the extent necessary to help with your health care or with payment for your health care. In the even of an emergency or your incapacity, we will use our professional judgement in disclosing only the protected health information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Your protected health information may also be used by our office to recommend treatment alternatives or to provide you with information about health-related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial, or administrative proceedings, in response to a subpoena or court order, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials and/or to report suspected abuse, neglect, or domestic violence. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

**You have certain rights in regard to your protected health information,** which you may exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect, and copy your protected health information, with limited exceptions. A reasonable fee may be assessed.
- The right to request an amendment to your protected health information. We ma deny your request in certain situations.
- The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, or health care operations or based on your previous authorization.
- The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.

**We are required by law to maintain the privacy of your protected health information** and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

**This notice is effective as of April 14th, 2003,** and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effected for all protected health information that we maintain. Revisions of our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

**You have the right to file a formal, written complaint** with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:
**Woon's Healing Arts**
**115 S. 8th Street**
**Tacoma, WA 98402**
**Phone 253-272-9959 Fax 253-272-5595**

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201

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**Christopher Woon L.Ac** **Cathryn Woon D.C**

## Notice of privacy practices Receipt and Acknowledgement of Notice

Patient/Client Name:

_____

Date of birth: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Woon's Healing Arts Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Woon's Healing Arts at the above address.

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**Signature of Patient/Client** **Date**

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**Signature of Parent, Guardian, or Personal Representative** **Date**

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**If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)**

☐ **Patient/Client refuses to acknowledge receipt:**

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**Signature of Staff Member** **Date**