Privacy and Sharing of Information

The Heath Information Portability and Accessibility Act (HIPAA) was designed to maintain the privacy of the “protected health information” that you share with a practitioner in order to get care. Your personal health information is not disclosed to others unless you authorize me to share it with them OR a law authorizes me to share it. The information I gather includes -financial (such as billing transactions) -medical (such as family history, treatment notes, test results, and communication with other healthcare providers) -identity (such as address, birthday).

You have the right to -see/copy the information I gather by making a written request to me and paying for any applicable copying costs. You may also correct the information I have kept. -designate other individuals with whom I may share this information as necessary -receive a copy of this policy and to have your questions about it answered. -complain: first, please communicate with me and, if unresolved, you may file a complaint with the Washington State Department of Health and/or the U.S. Secretary of Health and Human Services. I have obligations to use this information for the purposes of -providing you with services and treatment, -collecting payment, and -complying with legal requirements such as mandated reporting of certain diseases to the Department of Health or of suspected abuse/neglect/or domestic violence, or responding to Court Orders. You understand that e-mail, text and voice messaging are not deemed secure under HIPAA (fax communications and U.S. Mail are). Nevertheless, because these non-secure means of communicating are more effective and convenient, you waive any protections in order to have the convenience of discreet communications about your care (e.g. links to dietary resources) and account (e.g. an update on amounts due) via e-mail, voice mail, and text messaging.

In order to be in compliance with this law I - Limit access to facilities where records are kept (both physical and electronic); - Will NOT use your information for marketing nor will I sell it. - Do not initiate communication with you in public settings – please greet me first to let me know you would like to say hello and understand that I will continue to use discretion. -Accept cash or check. I can accept payments by card but I have no control over what happens with the personal information the card servicer collects.

I have been given the chance to review the privacy policy and have my questions answered. I agree to discreet communications via non-secure means for my convenience and understand the policy. *Required*

Cancellation policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole that could have been filled by another patient who needs to be seen. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment due to non-emergency circumstances, will be charged a cancellation fee that is not covered by insurance.

I am aware of the Cancellation Policy and agree to provide 24 hours notice should I need to reschedule. *Required*

Consent to Treat

If I am/may be or become PREGNANT, If I have or develop a BLEEDING DISORDER, or If I have or receive a PACEMAKER I WILL INFORM SHARONNE BEFORE TREATMENT.

Sharonne received her M.S. in Acupuncture from Bastyr University. She is board certified by the National Certification Commission for Acupuncture and Oriental Medicine. The Washington State Department of Health issued her License #AC 61006846 to practice East Asian Medicine.

The scope of practice for an East Asian medicine practitioner in the state of Washington includes the following modalities, some of which I may receive during a treatment with Sharonne: ·Acupuncture, with sterile, single-use acupuncture needles or lancets to directly or indirectly stimulate acupuncture points and channels; ·Stimulation of acupuncture points and channels with electrical, mechanical, or magnetic devices, including but not limited to Qi Gong, sonopuncture, laserpuncture, and aquapuncture; ·Manual therapies such as acupressure, cupping and/or dermal friction (Gua Sha), East Asian massage, and Tui Na; ·Application of heat and cold therapies, including but not limited to infra-red light and moxibustion; and ·Lifestyle recommendations based upon East Asian medical principles including dietary suggestions, herbal/supplement recommendations, breathing/relaxation techniques and exercise.

Acupuncture is extremely safe and precautions are taken in clinic to avoid side effects. Nevertheless, I am aware that a small percentage of acupuncture recipients may experience: Temporary exacerbation of existing symptoms, Minor bruising or discomfort, Light-headedness or weakness, And, in even more rare instances, infection, a punctured lung, or broken needles.

I have been ·advised of Sharonne’s qualifications, scope of practice, and the risks inherent in acupuncture, given the opportunity to ask questions and receive answers, and·informed that I may withdraw my consent and cease participation in any/all of these procedures. With this knowledge, I voluntarily consent to the procedures listed above and release Sharonne O’Shea, L.Ac., and Acorn Acupuncture, PLLC from any and all liability which may arise in connection with treatment, except for a failure to perform procedures with appropriate medical care. *Required*

Assignment of Benefits

1. I authorize the RELEASE OF ANY INFORMATION about my health to any insurance company working with me (including, as applicable worker’s compensation, PIP coverage, and health care insurance) and any attorney I have retained as necessary to process a claim for payment to Sharonne O’Shea, L.Ac. for treatment provided to me. I also authorize them to furnish to her any information regarding my claims under the policy.
2. In consideration of Sharonne O’Shea’s rendering of treatment to me without immediate compensation, I authorize and I ASSIGN MY RIGHT TO PAYMENT to Sharonne O’Shea, L.Ac. and Acorn Acupuncture, PLLC, for medical treatment rendered to me out of the proceeds of any judgement, settlement, worker’s compensation claim or insurance coverage.
3. With reference to any contracted insurance providing coverage to me for treatment, I understand, authorize, and agree that I will receive no payment due to me under the contract of insurance until Sharonne O’Shea, L.Ac. and Acorn Acupuncture, PLLC IS PAID IN FULL.
4. I GIVE ASSIGNMENT AND LIEN in any claims against a third party whose negligence may have caused my injury, up to the amount of the bill for treatment, to Sharonne O’Shea, L.Ac . and Acorn Acupuncture, PLLC.
5. In the event any insurance company obligated by contractual agreement to make payment to me or to Sharonne O’Shea, L.Ac. and Acorn Acupuncture, PLLC refuses to make such payment upon demand, I hereby IRREVOCABLY ASSIGN AND TRANSFER to her any CAUSE OF ACTION that exists in my favor against any such company, and authorize Sharonne O’Shea, LAc and Acorn Acupuncture, PLLC to prosecute that action either in my name or in hers and further to compromise, settle, or otherwise resolve the claim.
6. I permit a COPY OF THIS AUTHORIZATION to be used in place of the original.
7. I, hereby appoint Sharonne O’Shea, LAc and Acorn Acupuncture, PLLC and any of her duly authorized agents and employees to ENDORSE any and all checks, drafts or money orders which are made payable to the undersigned, for medical services or the like which have been, or are to be, performed by her.
8. I authorize and DIRECT ALL PAYMENT FOR TREATMENT I received be tendered directly to Sharonne O’Shea, LAc and Acorn Acupuncture, PLLC. This instruction is an assignment of my rights under the medical coverage of the insurance policy, workers compensation claim, or third party claim. Any sum of money paid under this assignment shall be credited to my account.

I agree to assign my benefits to Sharonne O'Shea, L.Ac. and Acorn Acupuncture, PLLC, to pay for my treatment. *Required*