



Candice Nelms, A.P., Dipl. O.M.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

I would like to receive telephone communication or messages via:
(Check all that apply)

- Home phone: _____
- Work phone: _____
- Cell phone: _____
- Pager: _____

Please print name

Please sign name (signature)

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our notice of Privacy Practices, but the acknowledgement could not be obtained because:

- Individual refused to sign
 - Communication barriers prohibited obtaining the acknowledgement
 - An emergency situation prevented us from obtaining acknowledgement
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INFORMED CONSENT & CONFIDENTIALITY AGREEMENT

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 methods of treatment may include, but are not limited to: acupuncture, moxibustion, cupping, electrical stimulation, tui-na and shiatsu (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 effects 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. 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 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 then known 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 for any future condition (s) for which I seek treatment.

For purpose of confidentiality, I give permission for my practitioner, **Candice Nelms, A.P., Dipl. O.M.** to leave a phone message at the following phone numbers: (1) _____ - _____
(2) _____ - _____ (3) _____ - _____

PATIENT SIGNATURE _____ DATE _____
(Or parent/guardian) Relationship if signing for patient: _____



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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised notice of Privacy Practices. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices at any time.

You will have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect any action that we took in reliance on this consent before we received your revocation, and we may decline to treat you or to continue treating you if you revoke this consent.

I authorize you to disclose health information to (leave message with, pick-up herbs etc.):

No person at this time.

Spouse: _____

Family member: _____

Friend: _____

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date: _____

WE MAY LEAVE A MESSAGE AT THIS # _____

REVOCAION OF CONSENT

I revoke my consent for your use and disclosure of my protected health information, payment activities, and healthcare operations.

I understand that revocation of my consent will not affect action you took in reliance on my consent before you received this written notice of revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my consent.

Signature: _____ Date: _____