

Consent for Treatment

Name: _____ Date of Birth: _____

Address: _____

May I leave a message with a person or on a recording? Yes or No please check appropriate box

Ph Day () _____ Y N Eve () _____ Y N

E-Mail Address: _____ Web: _____

In Case Of Emergency Contact:

Name: _____ Relationship: _____

Phone: Day () _____ Eve: () _____

I, _____ hereby voluntarily request to receive clinical services from Solara Attatharya, AP, DNBHE. I voluntarily consent that these services may include such types of treatments as homeopathy, acupuncture, acu-point injections, Mesotherapy, Tui Na therapeutic massage, cupping, herbal medicine, nutritional /dietary counseling, lifestyle counseling, ear candling, color, gem and aromatherapy, as well as other modalities within the scope of Chinese Medicine. I acknowledge that no guarantees have been made to me as to the effect of such examinations, treatment, therapy, or care of my condition. I further acknowledge that none of the above services is meant to be construed as the diagnosis or treatment of disease, but only as an aid to improve my natural wellness. I understand that prior to the beginning of any treatment; I will receive an explanation of the nature and purpose of the treatment. I recognize the potential risk and benefit of this procedure as described. **Risks:** In some cases, symptoms may relapse or intensify temporarily during the course of treatment before relief is sustained. **Rarely:** There may be temporary bruising, pain, lightheadedness, discomfort, infection, blistering, pneumothorax weakness, fainting, or nausea. Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. **Potential Benefits:** Drugless relief of presenting symptoms and improved balance of the body's energies, which may lead to prevention or elimination of the presenting problems and strengthen the constitution. I agree to the above named procedures. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I intend this consent form to cover the entire course of treatment for my presenting condition and for any future conditions for which I seek treatment. I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment. I hereby release Solara from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. **I am willing to be part of a team for wellness. If I do not plan to follow my physician's advice, I will tell her.** As a team, we may find a work-a-round to any part of the treatment I may not agree with or find difficult to comply with. I understand that I may refuse any and all services at any time. **I will also inform this clinic of all other types of treatments, herbs and over the counter substances, I am taking; if I become pregnant; if I am diagnosed with Hepatitis, AIDS, or an STD.** I understand that Solara Attatharya is not an MD and WILL NOT tell me to stop any treatment prescribed by an MD. I have read this information and Solara has verbally gone over this with me. I understand that all clinical information will be kept strictly confidential. Please Initial_____

Solara Attatharya, AP, is involved in research and in the training of other physicians. In some cases, she may want to use some or all of the information gathered in my case to share in this research, classes or inet consultation. I consent to the use of photo's, video or audio taping for these purposes. My name and other personal information, which may identify me, will be completely removed to maintain my confidentiality. I do I do not give permission for details of my case to be used. _____

Financial Responsibility

I understand even if I have insurance coverage, I am responsible for all fees connected with services rendered by Solara Attatharya and I agree to make payment in full at the time services are provided unless prior arrangements have been made. Returned checks and balances older than 30 days are subject to collection fees and interest charges. I am aware that I am liable for all legal expenses incurred with the collection of the account. **Cancellation Policy Please give 2 business days notice LESS THAN 48 BUSINESS HOURS NOTICE one free pass.** The second time will be billed at 50% of the consultation fee and 100% thereafter. *Your appointment time is reserved. If you miss your appointment, others who desire that appointment time cannot be served.* Fees for missed appointments are NOT covered by insurance. Please be on time. Try to call if you are running late. (Your appointment time may get shorter by the amount of time you are late or rescheduled.) If you are ill, please call us prior to your appointment and discuss it with us. Acupuncture can safely be utilized with almost all illnesses. I consent and authorize Solara Attatharya to transmit any information to my insurance company as required or requested for Solara to receive insurance compensation in connection with my child's treatment. My signature below indicates that I have read and agree to the above:

Signature of Client or Guardian _____

Date: _____

HIPPA Privacy Agreement Abundant Health Holistic Center

Statement of HIPAA: Consent for Use and Disclosure of Health Information as required by law of medical and other clinics

We are very concerned with protecting your privacy and will keep disclosure of any health info to a minimum. Please review this policy before signing below. You have a right to a copy of this policy. We reserve the right to change our policy practices as described in this notice. Notice of any changes will be posted in the office.

There are several circumstances in which we may have to use or disclose your health care information.

We may have to disclose your health information to another health care provider or to a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your condition or they referred you to us.

We may have to disclose your health information and billing records to another party if they may be responsible for payment or collection of payment for services provided you at this clinic.

We may need to use your health information within our practice for quality control or other operational purposes. Among other items, this may include telephoning or mailing appointment reminders or periodic greetings such as birthday or holiday cards. By signing this form, you are giving authorization to contact you with these reminders and information.

Your right to limit uses of disclosures includes the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree with your restrictions. However, if we agree with your restrictions, the restriction is binding with us.

Additionally, you may revoke your consent to us at any time; however, your revocation must be in writing. We will not able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Patient name: _____ Date of Birth: _____

Patient Address: _____ Apt # _____

City, State Zip _____

Type of PHI to be restricted or limited (Please check all that apply) Checking these means this information can't be verified or released to anyone including family members unless you sign more papers. How would you like your PHI restricted? No Restrictions Restrictions

- | | | | |
|---------------------------------------|--|---|--|
| <input type="checkbox"/> Home Phone # | <input type="checkbox"/> Patient History | <input type="checkbox"/> Home Address | <input type="checkbox"/> Office Address |
| <input type="checkbox"/> Occupation | <input type="checkbox"/> Office Phone # | <input type="checkbox"/> Name of Employer | <input type="checkbox"/> Spouse's Name |
| <input type="checkbox"/> Visit Notes | <input type="checkbox"/> Spouse's Ofc Ph # | <input type="checkbox"/> Hospital Notes | <input type="checkbox"/> Prescription Info |
| <input type="checkbox"/> Other | | | |

Please list any others (Physicians, spouse, family members, and or friends to whom we may release your private health information to:

I acknowledge that I was given the opportunity to read a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

I understand that this form will be placed in my records for six years. Date Expires: _____ 2016

Signature of Patient or Legal Guardian

Date