DISCLOSURE STATEMENT

Please read the following and sign below after you have had any questions answered and have understood this statement to your satisfaction.

Fee Schedule
Payment is due at the time of service. If your insurance does not cover this service, there is a time of service discount applied. The current discounted rates are:

Acupuncture

Initial Visit	$100 + cost of herbs
Follow-up Visit	$70 + cost of herbs

Holistic Nutrition, Health Coaching, and Lifestyle Consultations

Initial Visit	$125
Follow-up visits	$75

Manual/Massage Therapy

½ Hour Session	$40
1 Hour Session	$70

Any services offered by an employee at Vibrant Living Wellness Center are not intended to substitute for those offered by a licensed medical doctor when needed. Referrals are made for further workup and treatment when appropriate. Patients may seek a second opinion from other health care practitioners or terminate therapy at any time. The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy.

This clinic complies with the rules and regulations promulgated by the Georgia Composite Medical Board, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are utilized.
In a professional relationship, sexual intimacy is never appropriate and should be reported to the licensing board immediately.

The practice of acupuncture is regulated by the Georgia Composite Medical Board. If you have comments, questions, or complaints, contact the Georgia Composite Medical Board, 2 Peachtree Street, NW, 6th Floor, Atlanta, GA, 30303-3465, (404) 656-3913.

.I have read and understand this document, have had an opportunity to have any and all questions answered on the subject, and freely seek the services offered
.

_____ _____
Patient's or Guardian's Signature Date

Vibrant Living Wellness

It's Your Life... Live It In Health!

OFFICE POLICIES

Cancellations & missed appointments. Please provide 24-hour notice of cancellation prior to your scheduled appointment. If you miss an appointment or cancel within 24 hours, you will be charged the full price of the missed session, payable before the next appointment can be scheduled. Sessions booked with gift certificates or prepayment will forfeit said prepayment or gift certificate in the event of a no show or late cancellation.

Reasons for being dismissed/denied treatment: Patients who show inappropriate conduct, non-or-late payment of fees, or safety concerns may be denied treatment.

FINANCIAL POLICY

Your payment is due in full at the time of service. For your convenience, we accept cash, checks (from established patients) or credit cards. For checks returned to us as unpaid by your bank, you will be charged a $30 fee in addition to the original check amount.

INSURANCE POLICY

Vibrant Living Wellness Center does not currently file most insurance. We are a direct provider with the VA and can file a VA claim with a pre–approved referral. However, we can provide you with a super bill that you can submit to your insurance company for reimbursement if you have acupuncture or massage/manual therapy coverage. We also accept HSA payments.

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In the case that your insurance company sends a check directly to you for the payment of the treatment, you hereby agree to endorse the check to Vibrant Living Wellness Center and turn over payment with accompanying Explanation of Benefits form.

Procedure Code	Description of Service	Billed Charge	Time of Service Discount
99203	New Px Evaluation	$100	$100
97810	Acupuncture, first 15 min	$100	$70
97811	Acupuncture, additional 15 min	$70	0
97813	Acupuncture, electrical first 15 min	$100	$70
97814	Acupuncture, electrical add 15 min	$70	0

RECORDS RELEASE & ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information to claims for benefits submitted. I further agree and authorize Leona Harter, L.Ac. to submit claims for benefits, for services rendered, without obtaining my signature on each claim. I understand that I am financially responsible for all charges incurred, whether or not they are covered by my insurance company. This authorization shall remain valid until written notice is given by me revoking said authorization.

I authorize Vibrant Living Wellness Center to charge my credit card for the agreed upon purchases and understand that my information will be saved on file for future transactions on my account or in the event of a late cancellation/no show. If I choose not to provide a credit card, I understand that services may be refused at the owner's discretion and prepayment will be required for any future services.

Patient's Signature Patient's Name Date

Vibrant Living Wellness

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Consent to Treatment

I hereby request and consent to the services and other procedures within the scope of the practice of acupuncture or massage therapy on me (or on the patient named below for whom I am legally responsible) by any practitioner associated within this practice. I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, herbal therapy, massage, Qi Gong, nutritional suggestions, and lifestyle coaching.

I understand that acupuncture, moxibustion, electrical stimulation, cupping, and gua sha are all safe methods of treatment. The historical record and modern research indicate that the above-named modalities have an exceptional safety record. However, adverse effects can occur during and after treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting or nerve damage. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential risks of moxibustion are burns, blistering, or scarring. Temporary discoloration or redness lasting a 1 – 5 days is a common side effect of cupping and gua sha.

Most conditions require an average of 6-12 treatments, although some will respond within 4-6 treatments and others may require a longer series –this depends on the severity and the chronic nature of the chief complaint. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I will notify my practitioner should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could possibly induce miscarriage. Otherwise, Chinese medicine and massage therapy can be very beneficial in the pregnancy and birthing process.

I understand that herbal and nutritional supplements recommended to me by my practitioner are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects are nausea, gas, stomach ache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my practitioner as soon as I experience any discomfort or adverse reactions.

I understand it is my responsibility to disclose fully any medications, including herbs and supplements that are currently in use. I understand that it is my responsibility to inform my physicians and other healthcare professionals that I am receiving acupuncture and/or massage treatments. I will notify my practitioner prior to needling if I am on any anticoagulant therapy.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. I have been informed that I have the right to refuse any form of treatment. I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I give my permission and consent to treatment

Signature: _____ Date:_____

Acknowledgment of Notice of Privacy Practices and Consent to Treat

With my consent, VIBRANT LIVING may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to VIBRANT LIVING's Notice of Privacy Practices for more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

With my consent, VIBRANT LIVING may call my home or any other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, VIBRANT LIVING may mail to my home or other designated location any items that assist the practice carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked as personal and confidential.

With my consent, VIBRANT LIVING may email and/or text me appointment reminders and patient's statements. I have the right to request that VIBRANT LIVING restrict how it uses or discloses my PHI to carry out TPO.

By signing this form, I am consenting to VIBRANT LIVING's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, VIBRANT LIVING may decline to provide treatment to me.

I, _____, hereby acknowledge that I read and reviewed a copy of VIBRANT LIVING's Notice of Privacy Practices and fully understand this consent form. I am consenting to the use and/or disclosure of my health information to treat me and arrange for my medical care. I am consenting to be treated.

_____

Signature of Patient or Parent/Legal Guardian Date

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

USES AND DISCLOSURES OF HEALTH INFORMATION

Treatment: We may use your health information for treatment or disclose it to a physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the Federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include: quality assessment and improvement activities, reviewing competence of healthcare professionals, evaluation practitioner/provider relationships, conducting training programs, accreditation, certification, and credentialing or licensing activities. We may also disclose your information to another healthcare provider or organization that is subject to the Federal Privacy Rules and that has a relationship with you to support some of their health care operations.

On Your Authorization: You may give us written authorization to use your health care information or disclose it to anyone for any purpose. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help you with your health care or with payment for your health care. Before we disclose your health information, we will provide you with an opportunity to object to our use or disclosure. If you are not present or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We will also use our experience and professional judgment to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, or similar forms of health information.

Courtesy Calls & Appointment Reminders: We may use or disclose your health information to provide you with appointments reminders, courtesy calls, etc. via voicemail, text, email, postcards, and letters.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- As required by law
- For public health activities (disease/statistic & child abuse reporting, work-related illness or injury)
- To report abuse, neglect, or domestic violence In response to court and administrative orders and other lawful processes

YOUR RIGHTS-You Have The Right To:

- Request a copy of our Privacy Practices Notice at any time
- Look at and obtain a copy of your health information
- Deny courtesy calls, emails, or letters sent by our office
- Request a restriction on certain uses and disclosures of your health care information
- Receive confidential communications regarding your health information
- Revoke authorizations that you made previously in regards to your protected health information

OUR RESPONSIBILITIES-We Have The Right To:

- Maintain the privacy of your health information as required by federal and state law
- Provide you with a notice of our Duties and Privacy Practices
- Abide by the terms of this notice