HUNT VALLEY ACUPUNCTURE AND CHINESE HERBAL MEDICINE

Rabab Al-Amin, M.Ac., L.Ac., Dipl. Ac. (NCCAOM)
410-299-0752 HuntValleyAcu@gmail.com 215 Wickersham Way #1. Cockeysville, MD. 21030

Billing Policy & Acknowledgement of HIPAA Privacy Policy & Consent to Treatment Agreement.

The following sets forth the general billing policy of **Hunt Valley Acupuncture & Chinese Herbal Medicine (HVA) / Rabab Al-Amin, L.Ac., M.Ac.** Please review this information and sign where indicated.

- I understand that payments to **HVA / Rabab Al-Amin, L.Ac., M.Ac.** are due at the time of service.
- I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a $25 NSF fee. I further understand that to rectify my account, I will be required to pay with cash, a money order, cashier's check, or credit card.
- I understand that I will be billed for any balance due and that I have a financial responsibility to pay these amounts. I understand that in the event there is an outstanding balance on my account that if I have not made payment prior to the second statement being mailed, that the second statement will be marked as "Final Notice" and may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.
- I understand that I will be charged the full fee if my appointment is canceled in less than 24 hours.
- I understand that this is the Notice of Privacy Practices as required by HIPAA from **HVA / Rabab Al-Amin, L.Ac., M.Ac.,** and understand my rights with regard to my personal health information disclosure.

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those
- restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?

May we leave a message on your answering machine at home or on your cell phone?

May we discuss your medical condition with any member of your family?

If YES, please name the members allowed and their phone numbers:_____

_____

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I have not been guaranteed any success concerning the uses and effects of Chinese Herbal Medicine. I understand that I am free to discontinue treatment at any time.

Possible Side Effects/Healing Response:

I understand that treatment may result in certain side effects, including temporary pain or discomfort, and temporary aggravation of symptoms existing prior to intake of herbs. Conventional medical therapy also may be indicated, either in response to an emergency or as deemed necessary in the discretion of a licensed physician.

Medical Referral:

I understand that if there is a worsening of my ailment or condition, or if it does not improve within the time estimated by the acupuncturist at the beginning of the treatment, or if a new ailment or condition arises, that I should consult a licensed physician.

Infectious Disease/Clean Needle Procedures:

I understand that there is infectious disease carried through the air, through physical contact, and through body fluids. I understand that the practitioner follows universally prescribed precautions to guard against the spread of infections. I understand that the practitioner washes her hands, wears gloves and a mask before preparing each herbal formula to guard against contagions by contact.

I understand that my questions about the safety of Chinese Herbs, nutraceuticals and the precautions taken by the practitioner are most welcome, and will be answered as fully as possible.

At times, I may not be able to produce lot numbers for raw, granule, tincture, sachets, or salves and balms Chinese herbs.

Please give at least 24 hour notice for cancellation.

I understand that I will be charged the full fee for missed appointments, or less than 24 hours cancellations.

By signing below, I agree to the above named procedures. I intend this consent to cover the entire course of treatment for my present condition(s).

My signature below confirms that I have read and understand these consent to treatment agreement, billing policies, privacy practices and my financial obligation as pertains to the health care practitioner, **HVA / Rabab Al-Amin, L.Ac., M.Ac.**

Patient's Printed Name:_____

Signature:_____

Date _____ Witness:_____

Legal Guardian to Patient (if patient is minor or incapable of signing)_____