Green Lake Health Center, LLC Notice of Privacy Policies and Practices (HIPAA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Legal Duty

Green Lake Health Center, LLC (GLHC) is committed to protecting your privacy and is required by applicable federal and state laws to maintain the privacy of your protected health information. "Protected health information" is your individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer, or a health care clearinghouse, that relates to: (1) your past, present, or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present or future payment for the provision of health care to you.

We are required to give you this notice about our privacy practices, which describes how we may use, disclose, collect, handle and protect our members' protected health information; our legal duties; and your rights concerning your protected health information. We are required to maintain the privacy of your protected health information and inform you of your right to be notified following a breach of your unsecured protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 9/23/2013 and will remain in effect until we replace it.

We will continually review our privacy practices to ensure the privacy of our members' protected health information. Due to changing circumstances, it may become necessary to revise our privacy practices and the terms of this notice at any time, provided that changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices, and the new terms of our notice will become effective for all protected health information that we maintain, including protected health information we created or received before we made the changes. If we make a significant change in our privacy practices, we will revise this notice and notify all affected patients. Changes to this notice will be available at the clinic, and we will provide you with either the revised notice or information about the changes and how to obtain a revised notice.

You may request a copy of our notice at any time. For more information about our privacy practices or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

In order to administer our medical billing and office, we collect, use and disclose protected health information for certain of our activities, including payment and health care operations. The following is a description of how we may use and/or disclose protected health information about you for payment and health care operations.

Payment and Health Care Operations: We may use and disclose your protected health information to bill for services provided to you by our providers: determine your eligibility for benefits, coordinate benefits, examine medical necessity, and/or contact referring providers for coordination of care. We may use and disclose your protected health information to: conduct quality assessment and improvement activities, manage our business and rate our risk. We may use and/or disclose your protected health information for all activities that are included within the definition of "payment" and "health care operations," but we have not listed all of the activities in this notice so please refer to 45 C.F.R. § 164.501 for a complete list.

Business Associates: In connection with our billing and health care operations activities, we contract with individuals and entities (called "business associates") to perform various functions on our behalf, or to provide certain types of services (such as billing claims and checking benefits and eligibility). To perform these functions or to provide the services, business associates will receive, create, maintain, use, or disclose protected health information, but only after we require the business associates to agree in writing to contract terms designed to appropriately safeguard your information.

Other Covered Entities: In addition, we may use or disclose your protected health information to assist other covered entities in connection with certain of their health care operations. For example, we may disclose your protected health information to your referring health care provider when needed by the provider to render treatment to you, and we may disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing.

Other Possible Uses and Disclosures of Protected Health Information

In addition to uses and disclosures for payment and health care operations, we may use and/or disclose your protected health information for the following purposes.

Benefits and Services: We may use your protected health information to contact you with information about health-related benefits and services, or about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities.

Others Involved in Your Health Care: Unless you object, we may release protected health information about you to a friend or family member who is involved in your health care, or to someone who helps pay for your care. We may also disclose protected health information about you to an organization assisting in a disaster relief effort so that your family can be notified about your condition, status or location.

Research, Death: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, medical examiner or funeral director.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the healthcare system, or government programs or its contractors, and to public health authorities for public health purposes. We may disclose your protected health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws.

Legal Proceedings and Enforcement: We may disclose your protected health information in response to a court or administrative proceeding or order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, we may disclose your protected health information to law enforcement official to locate or identify a suspect, fugitive, material witness, crime victim or missing person.

Inmates: If you are an inmate of a correctional institution, we may disclose your protected health information to the correctional institution or to a law enforcement official to provide health care to you, for your health and safety and the health and safety of others, or for the safety and security of the correctional institution.

Health Oversight Activities: We may disclose your protected health information to a health oversight agency for audits, investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions. Oversight agencies include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and compliance with civil rights laws.

Military and National Security: We may disclose to Military authorities the protected health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials protected health information required for lawful intelligence, counterintelligence and other national security activities.

Workers' Compensation: We may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

To You and on Your Authorization: We must disclose your protected health information to you, as described in the Individual Rights section of this notice below. You may give us written permission to use your protected health information or to disclose it to anyone for any purpose. We may use or disclose to a business associate or to an institutionally related foundation, your protected health information for the purpose of raising funds on our behalf. With each fundraising communication we will provide you with the opportunity to elect not to receive any further fundraising communications. Uses and disclosures for marketing purposes, disclosures that constitute a sale of protected health information and other uses and disclosures not described within this notice will only be made with your written authorization. If you give us authorization, you may change your mind at any time. Your decision to revoke your prior authorization will not affect any use or disclosures made while it was in effect.

Individual Rights

Access: You have the right to inspect and copy protected health information about you in a designated record set that may be used to make decisions about your care. To inspect and copy protected health information, you must submit your request in writing to the Privacy Officer. You may request that we provide copies in a format other than paper. We will use the format you request unless we cannot practicably do so. We may charge a fee for the costs of copying, mailing or other costs associated with your request. We may deny your request to inspect and copy in certain limited circumstances. If your request is denied, you may request a review of that decision. Under certain conditions, our denial will not be reviewable and we will inform you of that with our decision. The healthcare professional conducting the review will not be the person who denied your initial request. We will comply with the outcome of the review.

Accounting: You have the right to receive a list of instances in which we disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities. The first list you request will be free. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact the office for information on these fees.

Restriction: You have the right to request a restriction on the protected health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to these restrictions. If we do, we will follow our agreement, unless the information is needed to provide emergency treatment to you. A request to restrict your protected health information, must be made in writing and must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse. We will notify you if we end our agreement with you to restrict your protected health information.

Confidential Communications: If you believe that a disclosure of all or part of your protected health information may endanger you, you have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. For example you may ask that we contact you only at your work address or via your work email. Your request must be in writing and must state that the information could endanger you if it is not communicated in confidence by the alternative means or location you want. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect payment.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may submit in writing a statement disagreeing with the denial, which we will add to the information you wanted to amend. If we accept your request, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Web and Email Privacy

We want to assure Users of our Website (meaning any individual, including site visitors as well as those individuals who provide personal information via this Website, herein referred to as "User(s)") that their personal information is secure and maintained in confidence, consistent with applicable state and federal laws. By "personal information", we mean data that uniquely identifies an individual, such as a name, address, social security number, telephone number or other individually identifiable information.

Information Collected Online

General: From time to time, we may request personal information from you at our site in order to deliver requested materials to you, respond to your questions, or deliver a product or service. When you visit and navigate our site and when you communicate with us via our site, we will not collect personal information about you, unless you provide us that information *voluntarily*. How you use the GLHC Website will determine whether or not we need to collect information from you and how much information we collect. For many features, we do not require any information on who you are or ask questions about you. For some of our features, we need to either verify your identity through a login process, or collect sufficient information from you to provide the service of that feature.

Email, Product Inquiry: GLHC provides an email address for comments and questions. We invite Users to send secure messages to us regarding appointments or services. We retain copies of these secure messages for 1,000 days, but does not disclose secure messages to any non-affiliated third parties. Access to the information provided through the use of these secure messages will be limited to those GLHC representatives or other appropriate third parties who need to view this information to respond to the inquiry or to perform their job responsibilities. We also invite Users to send payments via PayPal through a link on the website. Users should also review the privacy policy contained on PayPal.com for information regarding how they use the information.

Use of Cookies: A cookie is a small piece of information about an Internet session that may be created when an individual accesses a Website. Cookies can contain a variety of information, including the name of the Website that issued them, where on the site the User visited, passwords, and even Users' names that have been supplied via forms. Note that most Web browsers can be modified by the User to prevent cookies from being attached to the User. Our Website uses cookies to facilitate easier navigation within the sites and to provide a higher level of convenience for Users.

Use of Information Collected Online or Through Email

GLHC does not sell your non-public personal information to anyone. Unlawful disclosure of your personal information, including social security number, is prohibited. All information submitted by any individual to us may be retained to provide a record of such communications and to comply with any applicable legal and/or regulatory requirements and may be verified for accuracy. In addition:

GLHC uses any information submitted by you on the website as well as information submitted by you on PayPal.com and any information sent directly to us via email to provide improved customer service, to provide relevant health care related information, to update information we have about you, and to monitor the effectiveness of our online services. In some cases, we may use such information to provide you with access to information on products and services offered by GLHC.

Your email address information will be used only for GLHC-related mailings and will not be given, sold or rented to any other party for any other use without your prior approval.

Information may also be "cleansed" by GLHC (stripped of any information which could identify you personally, such as your name or email address), aggregated with other data, and used for general research, classification purposes, marketing, or other purposes without permission, but only in non-individually identifiable forms.

Access to Information Collected Online

Employees: Certain GLHC employees may be provided with information regarding Users in order to respond to the individual's needs and provide requested information regarding specific products or services. GLHC employees are required, by written confidentiality statements, corporate policies, and state or federal laws or regulations to maintain the confidentiality of personal information and to use strict standards of care in handling the information. Employees who do not conform to these confidentiality requirements are subject to disciplinary sanctions that may include dismissal.

Affiliates, Business Associates and Service Providers

GLHC may disclose personal information of its Users collected through its Website as permitted by law to affiliates along with non-related service providers that assist GLHC in meeting the needs of its customers. Information collected by affiliates and non-related service providers may also be shared with GLHC as permitted by law. Personal information is treated with the same standards of confidentiality that GLHC applies to other confidential information. GLHC's affiliates are subject to corporate policies regarding privacy and confidentiality and GLHC's non-related service providers and Business Associates are legally bound by contract to employ at least the same strict standards of confidentiality as employed by GLHC.

Third Parties: Other than as set forth above, GLHC does not transmit any personal information collected through its Website to any third party without the permission of the individual.

Compliance Assurance

Security: GLHC uses commercially reasonable computer security technology selected and implemented to provide adherence to the security and privacy policies described in this online posting. Although we make reasonable efforts to protect your information from unauthorized use or alteration, you should be aware there is always some risk in sending information over the Internet.

Account Access: Consistent with the requirements set forth under certain state and federal laws, GLHC grants access to personal information only to those employees, affiliates and third parties as required to provide healthcare services, or as you permit. All such employees, affiliates and third parties are subject to privacy policies, at least as restrictive as the policy described in this online document.

Internal Compliance Program: GLHC maintains an internal privacy compliance program to ensure compliance with this privacy policy. This program includes oversight of the compliance program by a Privacy Officer whose function is to create, maintain, and enforce privacy procedures in accordance with this policy. GLHC reserves the right to amend this policy at any time.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed below.

If you are concerned that we may have violated your privacy rights or you disagree with: (1) a decision we made about access to your protected health information, (2) our response to a request you made to amend or restrict the use or disclosure of your protected health information, or (3) our response to your request to have us communicate with you in confidence by alternative means or at an alternative location, you may complain to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Paper Copy of This Notice: You have the right to a paper copy of this notice, and you may ask us to give you a copy of this notice at any time.

Contact Office: Green Lake Health Center

Telephone: (206) 527-9709

Fax: (206) 526-2991

Website: www.GreenLakeHealth.com

Address: 9714 – 3rd Ave NE Suite 103

Seattle, WA 98115

GREEN LAKE HEALTH CENTER
9714 – 3rd Ave NE SUITE 103 • SEATTLE, WA • 98115 • PHONE (206) 527-9709 • FAX (206) 526-2991

Patient Name: Date of Birth:

Address: Apt#: City: State: Zip:

Occupation: Employer: Email:

Marital Status: □ Single □ Married □ Divorced □ Other

□ Home#: ( ) □ Cell#:( ) □ Work: ( )

**Please indicate the best number to leave a confirmation call or detailed message by checking the appropriate box above.*

Emergency Contact # & Name:( )

Is it OK to leave a detailed message with this person? □Yes □ No

PRIVATE HEALTH INSURANCE

Insurance Company Name: Attending Physician:

Policy / I.D.# (this may be alphanumeric) Group / Plan #:

IF YOU ARE **NOT** THE PRIMARY SUBSCRIBER OF THIS POLICY PLEASE COMPLETE THE FOLLOWING

Name of Subscriber: Subscribers Date of Birth: Subscribers Sex: M or F

What is your relationship to the subscriber? Subscribers Employer:

SECONDARY HEALTH INSURANCE

Insurance Company Name: Attending Physician:

Policy / I.D.# (this may be alphanumeric) Group / Plan #:

IF YOU ARE **NOT** THE PRIMARY SUBSCRIBER OF THIS POLICY PLEASE COMPLETE THE FOLLOWING

Name of Subscriber: Subscribers Date of Birth: Subscribers Sex: M or F

What is your relationship to the subscriber? Subscribers Employer:

AUTO ACCIDENT INSURANCE *WE DO NOT ACCEPT THIRD PARTY CLAIMS* - Submit Your PIP INS

Claim #: Date Opened: Date of Injury:

Insurance Company Name: Attending Physician:

Adjusters Name: Telephone#:

WORKERS COMPENSATION CLAIMS

Claim #: Date Opened: Date of Injury:

Insurance Company Name: Attending Physician:

Adjusters Name: Telephone#:

Green Lake Massage Health Center requires a minimum of 24 *business hours* notice to cancel or reschedule an appointment.
Failure to give the minimum 24 hours notice will result in the standard no-show charge.
I agree to accept these charges if I fail to give the minimum notice or if an appointment is missed for any reason.

Initials

Y N Have you ever had professional massage therapy treatment?
Y N Have you ever had professional acupuncture before?
Y N Do you have arthritis?
Y N Do you have varicose veins or blood clots?
Y N Do you wear contact lenses?

Y N Do you have high blood pressure?
Y N Are you pregnant? If so, how far?_____
Y N Do you have spinal problems?
Y N Do you have any contagious or infectious diseases? Please list:___

Y N Do you exercise regularly? Please describe:

Y N Do you take any medications? Please list and indicate what they are treating:

Y N Have you ever had surgery? Please list:

Y N Have you recently suffered a severe injury or illness? Please describe:

Y N Do you have any skin problems or allergies? Please list:

Y N Do you have any areas that need special attention? Please describe:

The majority of my pain is located:

To answer the questions below, please use the following scale to rate your pain: 0 = No Pain; 5 = Moderate Pain; 10 = Worst Possible Pain

With no activity my pain intensity Is 0 1 2 3 4 5 6 7 8 9 10 Is it constant? Y N

When I lift	0 1 2 3 4 5 6 7 8 9 10	When I dress	0 1 2 3 4 5 6 7 8 9 10
When I read	0 1 2 3 4 5 6 7 8 9 10	When I walk	0 1 2 3 4 5 6 7 8 9 10
When I work	0 1 2 3 4 5 6 7 8 9 10	When I sit	0 1 2 3 4 5 6 7 8 9 10
When I drive	0 1 2 3 4 5 6 7 8 9 10	When I stand	0 1 2 3 4 5 6 7 8 9 10
When I sleep	0 1 2 3 4 5 6 7 8 9 10	When I type	0 1 2 3 4 5 6 7 8 9 10

Are there any other daily activities that your pain has affected? What are they and how?

If you have been involved in an accident please provide a description of what happened.

I hereby authorize Green Lake Health Center, LLC (GLHC) to **release any and all medical information** to the facilities and/or persons listed on page 1 including: insurance carrier(s), my designated attorney, now or in the future, and/or to my physician(s), if necessary, for the purposes of payment of my medically related outstanding debts, administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of this signing until revoked in writing, to both my insurance carrier and to the provider of services.

Payment Agreement: All payments are due at the time of service, unless other arrangements have been made in advance. All professional services rendered are charged to the patient and the patient is responsible for all fees, regardless of insurance coverage. I understand I am responsible for charges not covered by this assignment including finance charges, non-covered services, deductibles, co-payments, and co-insurance payments required by my insurance policy or certificate. I further agree that in the event of non-payment, I will bear the expenses of collection and/or court costs and/or reasonable legal fees, should this be required. I understand if my commercial insurance has not paid my bill within 60 days of my visit(s) for my services received by GLHC, I am responsible and I will then make whatever arrangements are necessary and available to me to pay all unpaid charges.

Assignment of Benefits: I hereby assign GLHC all money to which I am entitled for medically related expenses received at, or through GLHC. The payment shall not exceed my indebtedness. Any payment that GLHC receives from the insurance carrier beyond my indebtedness shall be refunded to me or the insurance company when my outstanding bill(s) have been paid.

I understand I may request a copy of any and all of my medical records for a reasonable fee or a fee allowed by State Statue or Workers' Compensation Statue. Any copy of this document shall be as valid as if it were the original. I have read the above authorization to release medical records, assignment of benefits, and payment agreement, and hereby acknowledge that I understand it. The payment agreement portion of this document may not be revoked in writing or otherwise.

Signature: **Date:**
(Patient)

Signature: **Date:**
(Parent or Guardian if Patient is under 18)

CONSENT TO TREAT

and

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES AND PRACTICES

By signing this form, you are agreeing that you:

1.) consent to receive massage therapy and/or acupuncture at Green Lake Health Center, as is legally required per WAC 246-830-565; and

2.) have received a copy of Green Lake Health Center's Notice of Privacy Policies and Practices, which describes how we use and disclose your health information. You have the right to refuse to sign this acknowledgment, in which case we must document our good faith effort to obtain your acknowledgment and the reason why it was not obtained.

Green Lake Health Center reserves the right to change the privacy policies that are described in the Notice of Privacy Policies and Practices. You may obtain a revised Notice of Privacy Policies and Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of your next appointment, or through e-mail.

You have the right to request restrictions or limitations on your health information used for treatment, payment or health care operations. You may request us to limit disclosure to someone involved in your care or in payment for your care by written request.

Please print name and sign below:

I consent to receive massage therapy and/or acupuncture from a licensed massage therapist (LMT) and/or licensed acupuncturist (LAC) at Green Lake Health Center. I agree to update my therapist at every appointment with health information relevant to my safety for receiving massage therapy and/or acupuncture. I agree to communicate with my therapist regarding appropriate pressure, areas to treat, areas to avoid, and anything pertaining to my wellness and comfort during the treatment. I understand that I will be draped during my massage and/or acupuncture appointment, and that in general only the area being worked on will be uncovered. I understand that LMTs do not diagnose, and that both legal and health concerns place limitations on my massage treatment. I understand that I may address any questions or concerns about draping and/or appropriate treatment with my therapist. I have received a copy of Green Lake Health Center's Notice of Privacy Policies and Practices.

Patient or Personal Representative Name Date

Patient or Personal Representative Signature Date

FOR OFFICE USE ONLY
We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy Policies and Practices from this patient but it could not be obtained because:

- ❑ The patient refused to sign
- ❑ Due to an emergency situation it was not possible to obtain an acknowledgement We weren't able to communicate with the patient
- ❑ Other (Please provide specific details)

Employee signature: Date:

GREEN LAKE HEALTH CENTER
9714 – 3rd Ave NE SUITE 103 • SEATTLE, WA • 98115 • PHONE (206) 527-9709 • FAX (206) 526-2991

Written Waiver to Continue East Asian Medical Treatment

SECTION 1:

I,_____ **(patient first name, last name)** herby authorize the following therapist to perform the following procedures:
Julie Swanson (Jenkins), E.A.M.P., M.Ac., L.M.T. who received her Masters of Science in Acupuncture in June 2008 from Bastyr University, and Medicine, and who is currently licensed in the state of Washington (Lic # AC60058151)

Jeznee Lyons, E.A.M.P., who received her Masters of Science in Acupuncture from Bastyr University, and Medicine, and who is currently licensed in the state of Washington (Lic # AC60707200)

- **Acupuncture**: the insertion of special sterilized, disposable needles through the skin into the underlying tissues at specific points on the surface of the body.
- **Cupping**: a technique used to relieve symptoms by applying cups made of glass to the skin with a vacuum created by a hand pump.
- **Plum Blossom**: multi-needle device applied to areas of the body with a light-to-moderate tapping technique.
- **Moxabustion**: the burning of the herb artemsia on or near the body to warm it, strengthen it, and relieve symptoms. Moxa comes in several forms such as stick, ball, cone or rice grain.
- **Dietary Advice**: food and herbal advice based on traditional Chinese medical theory.
- **Guasha**: the scraping or rubbing of an area with a ceramic spoon.
- **Sonopuncture (Acutonics)**: the use of tuning forks to help heal the body with sound waves and vibration. The forks are placed near and on the body, often on acupuncture points and energy meridians.

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: Although uncommon, there is a potential for acupuncture to produce some discomfort or pain at needled sites, minor bruising, or infection. It may also cause needle sickness, a broken needle, temporary discoloration of the skin, and potentiality an aggravation of symptoms existing prior to the acupuncture. Clients with severe bleeding disorders or pace-makers should inform their practitioners prior to treatment.

Potential benefits: drugless or drug-reduced relief of presenting symptoms and the improved balance of body energies which may lead to prevention or elimination of the clients main complaint(s).

SECTION 2:

Law requires the Department of Health to develop the requirements for the written waiver for East Asian medicine practitioners to use when the practitioner sees a patient with a potentially serious disorder. (18.06.140 RCW) Potentially serious disorders include, but are not limited to:

- Cardiac conditions including uncontrolled hypertension;
- Acute abdominal symptoms;
- Acute undiagnosed neurological changes;
- Unexplained weight loss or gain in excess of fifteen percent body weight within a three-month period;
- Suspected fracture or dislocation;
- Suspected systemic infection;
- Any serious undiagnosed hemorrhagic disorder; and
- Acute respiratory distress without previous history or diagnosis.

I may have a potentially serious disorder: □Yes □ No **(If no, skip to Section 3)**

I,_____**(patient first name, last name)** acknowledge I may have a potentially serious disorder. Julie Swanson (Jenkins), E.A.M.P., M,Ac., L.M.T, or Jeznee Lyons, E.A.M.P, requested a consultation or recent diagnosis from a physician or physician's assistant, osteopathic physician or osteopathic physician's assistant, naturopath or ARNP on that potentially serious disorder. I acknowledge that failure to pursue treatment from my primary health care provider may involve certain health risks.

I, nonetheless, refuse to authorize a consultation or to provide a recent diagnosis from such a primary health care provider and wish to continue with treatment.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Julie Swanson (Jenkins), L.Ac. M.Ac, L.M.T. or Jeznee Lyons, E.A.M.P, regarding the cure or improvement of my condition(s).

Signature: **Date:**

SECTION 3:

I understand the services and techniques the East Asian medicine practitioner is authorized to provide will not resolve my underlying potentially serious disorder(s).

I hereby release Julie Swanson (Jenkins), L.Ac. M.Ac, L.M.T, Jeznee Lyons, E.A,M.P 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 understand that I am free to withdraw my consent and to discontinue participating in these procedures at any time.

Signature: **Date:**

GREEN LAKE HEALTH CENTER

2018 ACUPUNCTURE PRICING PLANS

We offer two methods of payment for your acupuncture treatment and you may choose the plan that best suits your needs. Please read carefully and choose the plan that you prefer. This information will enable us to better serve you and help us to avoid misunderstanding in the future. If special financial arrangements are necessary, please consult with the billing manager during your initial consultation.

CHECK ONE:

___ PLAN 1:
The self-pay plan means that all fees will be paid when rendered. Fees are discounted for payment at time of service.
60 Minute Session (includes moxa and/or cupping and/or infrared treatment) **$95.00**

___ PLAN 2:
If you have insurance and we are preferred providers, we will bill for you as a courtesy. Payment for deductible, if it has not been met, is the responsibility of the patient, as well as any copayment or remaining balance after insurance payment. Your co-pay is due as services are rendered. You are also responsible for portions of your bill that exceed your insurance limits. Additional services, such as moxa, infrared, and cupping, will be billed to your insurance company. If your insurance company does not pay for these additional services, a negotiated rate may be available.

ACUPUNCTURE SERVICES (acupuncture billed to insurance will be billed for 3 units)

Acupuncture	**$50.00 per unit**
Acupuncture with Electrical Stimulation	**$70.00 per unit**

ADDITIONAL SERVICES

Moxa Treatment	**$15.00**
Infrared Treatment	**$15.00**
Cupping Treatment	**$15.00**

EVALUATIONS

New Patient Evaluation – Expanded	**$100.00**
New Patient Evaluation – Limited	**$85.00**
New Patient Evaluation – Minimal	**$60.00**
Established Patient Evaluation – Detailed	**$100.00**
Established Patient Evaluation – Expanded	**$85.00**
Established Patient Evaluation – Limited	**$60.00**
Established Patient Evaluation - Minimal	**$35.00**

New patient appointments will generally be 60 minutes and consist of a New Patient Evaluation and limited acupuncture treatment. Return visits will be 60 minutes and consist of full treatment acupuncture services. Established Patient Evaluations will occur every 6 weeks or if there is more than a 6 week gap between appointments or as needed.

I understand that all responsibility for payment of services provided in this office for myself and/or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. I permit this office to endorse co-issued remittances for the conveyances of credit to my account. In the event payments are not received by the agreed upon dates, I understand that a 2.5% finance charge will be added to my account. I agree to pay all attorneys and collection fees if this account is turned over for collection.
Please sign below to indicate your understanding of our financial policies. If you do not understand, please all us to review the policies with you until they are clear.

Signature:_____ Date:_____

Print Name:_____