Dancing Bear Healing Center

Acknowledgement of Receipt of Privacy Practices

This notice summarizes how health data about you may be used and shared and how you can get access to this data. IMPORTANT NOTE: This does not include all the details about our privacy policy. For more details, please read the NOTICE OF PRIVACY PRACTICES that your practitioner has provided you.

I. How we may use and share health data about you:

a. Treatment - To give you medical treatment or other types of health services.
b. Payment - To bill you or a third party for payment for services provided to you.
c. Health Care Operations - For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:

a. To you
b. As required by federal, state, or local law
c. If child abuse or neglect is suspected
d. Public health risks (for public health activities to prevent and control spread of disease)
e. Lawsuits and disputes (in response to a court or administrative order)
f. Law enforcement (to help law enforcement officials respond to criminal activities)
g. Coroners, medical examiners and funeral directors
h. Organ or tissue donation facilities if you are an organ donor
i. To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:

a. Patient directories - You can decide what health data, if any, you want to be listed in patient directories.
b. Persons involved in your care or payment for your care - We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:

a. Right to inspect your health record and to receive a copy of your health record upon request
b. Right to amend information in your health record you believe is inaccurate or incomplete
c. Right to know to whom we have disclosed your health information
d. Right to ask for limits on the health information data we give out about you
e. Right to receive communication from us about your health information in alternate ways
f. Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of this practice.

Signed: _____ _____

Signature of patient or person responsible for health care — Date

Beverly Lawrence, Ph.D., L.Ac.
Phone/Text: 480-422-7000 for Appointments or visit www. DancingBearAppointments.com
Web Site: www.DBHealingCenter.com

Dancing Bear Healing Center

Consent to Treatment Form

We require your consent to collect personal information about you and to provide various services. Please read this consent form carefully, initial each modality that might be used and sign where indicated below.

This Acupuncture Practice collects such information for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history to allow us to properly assess, treat and advise on your health care needs. By signing below, I do hereby voluntarily consent to be treated with acupuncture, Chinese medicinal herbs and Oriental Medicine and related modalities by a Licensed Acupuncturist at Dancing Bear Healing Center. I understand that acupuncturists practicing in the state of Arizona are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not make significant movements while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of Moxibustion. 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, mineral, and animal sources) that have been recommended are traditionally considered safe in the practice of Chinese 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 understand that the herbs need to be consumed according to the instructions provided orally and in writing. I understand that some herbs may have an unpleasant taste or smell. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

Women Only: **Pregnancy:** I will notify the acupuncturist should I become pregnant or if I am in the process of trying to become pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese Medicine treatment can be very beneficial in the pregnancy and birthing process.

I do not expect Beverly Lawrence or the Dancing Bear Healing Center staff to be able to anticipate and explain all possible risks and complications of treatment. I have carefully read and understand all the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation of anything regarding my treatment. I understand that my records will be kept confidential and will not be released without my written consent (unless in an emergency or by legal demand). I give my permission and consent to treatment.

By voluntarily signing below I show that I have read, or have had read to me, this 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.

Signature: _____ **Date:** _____

Signature of patient or person responsible for health care

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