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INFORMED CONSENT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed, or any other office or clinics, whether signatories to this form or not.

I understand that the methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, *tui-na* (traditional Chinese medical massage), Chinese herbal prescriptions, and nutritional and lifestyle therapy. I understand that herbs may need to be prepared and decoctions consumed according to instructions provided orally and in writing. The herbs may have an unpleasant odor or taste. I will immediately notify a member of the clinic staff of any unanticipated or unpleasant effects associated with the consumption of these nutritional or botanical supplements. I will keep the clinic staff informed of any pharmaceutical drug or nutritional supplement, which I have been prescribed, or I am taking, in order to allow proper timing and dosage of these nutritional or botanical supplements.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last several days, and dizziness or fainting. Bruising is a common side effect of cupping or *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 clinic uses sterile, single-use, disposable needles and maintains a clean and safe environment. Burns and/or scarring are a possible risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other risks may be present and other side effects may occur. The herbs and nutritional supplements (which are from plant, mineral and occasionally animal sources) that have been recommended are traditionally considered safe in the practice of oriental medicine, although some may be toxic in extreme doses. I understand that some herbs and nutritional supplements may be inappropriate during pregnancy. Some possible side effects of taking nutritional supplements are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I will notify the clinic staff member who is caring for me if I am or become pregnant.

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

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above 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 from this clinical staff.

Patient Name: Date of Birth:

Patient Signature:_____

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CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

Patient' s Name: Date of Birth:

Notice to Patient:

By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of **treatment**, various activities associated with **payment** and **health care operations**. Our **Notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. **All co-payments, deductibles and/or non-covered services are to be paid at the time of service. Your signature authorizes your insurance company to make payments directly to the physician.** If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer. You have the right to **revoke** your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you. You are entitled to a copy of this **Consent Form** after you have signed it.

Photograph Consent

Please check Box

In order to clearly identify our patients we would like to take your photograph for our records. Please check box. Please understand Worker's Comp requires a valid photo ID

☐ Yes, I consent to have my photo taken ☐ No, I do not consent to have my photo taken. I will provide valid photo ID

(To Be Completed by Patient or Patient's Representative)

I, _____have **read the contents of this Consent** Form and I **received a copy of the Notice of Privacy Practices**. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

<Patient Signature> _____

Patient's Signature or Signature of Patient's Representative Date:

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy 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)*

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DISCLOSURE STATEMENT

THE FOLLOWING NOTICE IS REQUIRED BY CALIFORNIA LAW

Doctors and Facilities

You may be referred to one or more of the doctors or facilities listed below for service. Each of the doctors listed below has a financial interest with or provides service to one or more of the other doctors and/or facilities listed.

Patient's Freedom of Choice

You are free to choose any doctor or organization you wish for obtaining services that may be ordered or requested for you by any of the doctors listed below. This choice, however, may be affected by restrictions imposed by your insurance plan. Your doctor would be happy to discuss alternatives with you
Potential sources of information concerning alternatives can also be obtained from
the Yellow Pages, the internet, or the county medical association.

The following addresses are provided for the filing of any complaints relevant to this notice or the services provided: Medical Board of California, 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815; Osteopathic Medical Board of California, 1300 National Drive, Suite 150, Sacramento, CA 95834; Board of Chiropractic Examiners, 2525 Natomas Park Drive, Suite 260, Sacramento, CA 95833-2931.

Doctors	**Facilities:**
Dr. Michael Post, MD **Dr. Ronald Fujimoto, DO** **Dr. Allen Kaisler-Meza, MD** **Dr. Melinda Brown, MD** **Dr. Elisa Yao, MD** **Dr. Amruta Samarth, MD** **Lindsay Anagnost, NP** **Jesse Phelps, PA** **Vijayasree Kumar, PA** **Patti Lee, NP** **Nsisong Usanga, NP** **Edward Cremata, NP**	RehabOne Medical Group, Inc. 13980 Blossom Hill Road Los Gatos, CA 95032 175 N Jackson Ave. Suite 109 San Jose, CA 95116 7880 Wren Avenue, Suite F-163 Gilroy, CA 95020 535 East Romie Lane, Suite 12 Salinas, CA 93901

I hereby acknowledge receipt of this notice. **Date:**

Signature: _____
Name:

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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.

State and Federal laws require us to maintain the privacy of your health information whether electronically, on paper and orally. We want to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on **April 14, 2003** and will remain in effect until it is amended or replaced by us. Amended July 1, 2014.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Maureen Cervelli. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, and disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $ *(0.10)* for each page and the staff time charged will be $ *(4.00)* per ¼ hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Out of Pocket: If you have paid for services "out of pocket" , in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to

that date would not have to be released. *(Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)*

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us. In writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and 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.

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Authorization to Release Information to Family Member / Friend

Patient's Name: _____ Birthdate:_____

I authorize ***RehabOne Medical Group, Inc***., to mutually exchange my medical information / my individually identifiable health information

with _____
(Family Member / Friend)

phone# _____

For the purpose of: _____

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance thereon.

Signature of Patient: _____

Date: _____

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Date:

EMERGENCY CONTACT INFORMATION

Name:
Date of Birth:

1) Emergency Contact Name:_____

Relationship to you:_____

Phone Number 1:_____

Phone Number 2:_____

2) Emergency Contact Name:_____

Relationship to you:_____

Phone Number 1:_____

Phone Number 2:_____