HIPAA Notice of Privacy Practices and Consent/Written Acknowledgement

I hereby consent to the use and disclosure of my protected health information by Spirit Point Medicine for the purposes of treatment, payment and healthcare operations, or as otherwise required by law.

- I acknowledge that I have a right to review or receive a printed copy of the Notice of Privacy Practices provided by Spirit Point Medicine prior to signing this consent. The Notice of Privacy Practices describes how medical information about me may be used and disclosed, and how I can access this information.
- I have the right to request restrictions to the usage and disclosure of my protected health information.
- I have the right to request an alternative to the standard method of communication of my protected health information.
- I understand that if I wish to revoke this consent at any time I will do so in writing and submit to the address listed below. I understand that while Spirit Point Medicine may honor these requests, they are not required by law to do so. I also understand that revocations will be honored as of the date they are received by Spirit Point Medicine at the following address:

  1516 SE 43rd Suite 2, Portland, Oregon 97215
- I understand that if I have any questions or complaints I may submit them in writing to the address above or contact Spirit Point Medicine by phone at: 503-208-6327.
- I am aware that Spirit Point Medicine reserves the right to change the terms of their Notice of Privacy Practices and to make new notice of Privacy Practices provisions effective for all protected health information that they maintain. In the event of amendments, Spirit Point Medicine make available a revised Notice of Privacy Practice for my review.

_____

Patient (print name)

_____ _____

Patient signature Date

_____ _____

Parent (under 18), Guardian, Responsible Party Date

THIS SECTION IS TO BE COMPLETED BY SPIRIT POINT MEDICINE IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:
[ ] Patient declined to sign this Written Acknowledgement [ ] Other (specify):

_____ _____

Name and title of employee Date

Patient Name:
DOB:

Spirit Point Medicine
1516 SE 43rd, Suite 2
Portland OR 97215

NON-COVERED SERVICES WAIVER/ACKNOWLEDGEMENT SERVICES/SUPPLEMENTS/SUPPLIES

I understand and agree to the following:

- Any and all supplements, supplies, herbs, formulas, etc. prescribed by my provider and/or purchased by me at Spirit Point Medicine are my full financial responsibility with payment to be made at the time of service/purchase. No open products can be returned to the clinic for refund under any circumstances.
- Spirit Point Medicine does not bill insurance carriers, health saving plans or any other like entities for any supplements, herbs, formulas, or supplies. It is my full responsibility to submit the required information to these entities for reimbursement.
- Treatment/services such as cupping, hydrotherapy, energy work, guasha etc. are generally not covered by insurance carriers and are my full financial responsibility (except where specifically determined by my insurance carrier as included in the primary treatment/service being rendered and clearly stated in the insurance contract with the treating provider).
- It is my full financial responsibility to pay for any charges previously covered/paid by my insurance carrier to the provider and/or Spirit Point Medicine which: 1) is later deemed by my insurance carrier to not be "medically necessary", and 2) has resulted in a partial or full refund request by my insurance carrier from the provider or Spirit Point Medicine.

I have fully read and understand the above agreements and information.

_____ _____

Patient (18 years or older) Date

_____ _____

Parent, Guardian, Responsible Party Date

Patient Name:
DOB:

Spirit Point Medicine
1516 SE 43rd, Suite 2
Portland OR 97215

Request for Medical Care

I, _____, hereby request and consent to examination and treatment with Acupuncture and Chinese Medicine with Shannon Conrad or other licensed practitioners who may serve as substitutes in their absence, hereafter the "Spirit Point Medicine practitioners".
I understand that I have the right to ask questions and discuss to my satisfaction :

(1) my suspected diagnosis(es) or condition(s)
(2) the nature, purpose, goals, and potential benefits of the proposed care
(3) the inherent risks, complications, potential hazards, or side effects of treatment
(4) reasonable available alternatives to the proposed treatment procedure
(5) potential consequences if treatment or advice is not followed and/or nothing is done

I understand that as part of the practice of acupuncture evaluation and treatment may include, but are not limited to:

- Physical exam and related assessments
- Homeopathic remedies
- Dietary advice and therapeutic nutrition, including use of foods, diet plans and nutritional supplements
- Botanical/ herbal medicines, prescribing of various therapeutic substances including plant, mineral, and animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures (which may contain alcohol), suppositories, tropical creams, pastes, plasters, washes, or other forms.
- Acupuncture, ear seeds, moxibustion, electric stimulation, cupping, gua sha, or other Chinese medical modalities.

Potential benefits of treatment include: restoration of the body's maximal and optimal functioning capacity, relief of pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.

Potential risks of treatment include: pain or bruising at the needle insertion site, allergic reactions to prescribed herbs or supplements, aggravation of pre-existing symptoms, burns from the use of moxa.

Please INITIAL the following:

_____ I understand that the Spirit Point Medicine practitioners will only prescribe natural therapies and medications if they believe that they are in the best interest of myself, the patient.

_____ I understand the US Food and Drug Administration has not approved Chinese herbs, nutritional, herbal or homeopathic substances; however, these have been used widely in China, Europe, and the USA for years.

_____ I understand that Spirit Point Medicine practitioners are not a psychologists or psychiatrists. Counseling services are provided for the support of improved lifestyle strategies only.

_____ I also understand that it is my responsibility to request that Spirit Point Medicine practitioners explain therapies and procedures to my satisfaction.

_____ I further acknowledge that no guarantee has been made to me concerning the results intended from any treatment provided to me.

Patient Name:
DOB:

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STATEMENT OF FINANCIAL RESPONSIBILITY

I understand and agree to the following general responsibilities:

- Financial options extended to me are based on the personal identification information and documentation I have provided.
- I am responsible as the patient or patient's guarantor for full payment of services rendered at the time of service, including all supplements, herbal formulas, as well as any additional expenses incurred in connection to my healthcare, such as: postage and delivery, shipping and handling, and phone calls to the provider or clinic wherein medical advice is provided.
- I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, I agree to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize Spirit Point Medicine to release information necessary to secure payment.
- I understand that there will be a minimum $90 fee for any appointment not cancelled within 48 hours of the scheduled appointment,
- Fees and rates are adjusted periodically and therefore may increase during the term of our engagement.

I understand and agree to the following with regards to current and/or future insurance billing:

- The verification of my health, motor vehicle accident, or workers' compensation insurance is used to determine if there is coverage for services through my insurance carrier and is NOT a guarantee of payment by my insurance carrier; I am fully responsible for being aware of any coverage exclusions.
- I am responsible for providing in a timely manner all accurate, current and thorough information and documentation required to verify my insurance coverage and/or bill my insurance carrier, including all relevant Coordination of Benefits information such as primary and secondary insurance, Medicare, Medicaid, etc.
- I understand that Spirit Point Medicine can require presentation of proof of insurance at any time, and that my insurance may need to be re-verified for specific coverage details as often as every six months.
- I am responsible for full payment of all services if any of the information I have provided is incorrect, falsified, or not provided in a timely manner and has resulted in Spirit Point Medicine's inability to directly bill for and/or receive reimbursement from my insurance carrier.
- I am responsible for full and timely payment of all insurance co-pays, deductibles, and co-insurance balances due, including any and all services not covered or paid by my insurance carrier (subject to individual provider insurance contract provisions).
- I may forfeit the privilege of billing my insurance carrier if I do not comply with any of my financial responsibilities or documentation requirements.
- I authorize release of information in my medical history to my insurance carrier and assign all benefits for unpaid services to Spirit Point Medicine. This release applies to support of the insurance billing process only.

I have fully read and understand the above agreements and authorizations.

_____ _____

Patient (18 years or older) Date

_____ _____

Parent, Guardian, Responsible Party Date

Patient Name:
DOB:

Spirit Point Medicine
1516 SE 43rd, Suite 2
Portland OR 97215

E-MAIL/TEXT CONSENT AUTHORIZATION FORM

Before sending e-mail/text communications to Spirt Point Medicine ("SPM"), please read and agree to the following information regarding the risks and conditions of e-mail/text use:

1. Risks Associated with e-mail/text. SPM offers patients the opportunity to communicate by e-mail/text. However, transmitting patient information by email/text has a number of risks that should be considered. These include, and are not limited to, the following risks:
    - E-mail/text can be circulated, forwarded, and stored in numerous paper and electronic files.
    - E-mail/text can be immediately broadcast worldwide and be received by many intended and unintended recipients.
    - E-mail/text senders can easily misaddress an e-mail/text.
    - E-mail/text is easier to falsify than handwritten or signed documents.
    - Backup copies of e-mail/text may exist even after sender or recipients have deleted their copy.
    - Employers and on-line services have a right to archive and inspect e-mails/texts transmitted through their systems.
    - E-mail/text can be intercepted, altered, forwarded, or used without authorization or detection.
    - E-mail/text can be used as evidence in court.
2. Conditions for the Use of e-mail/text. SPM will use reasonable means to protect the security and confidentiality of e-mail/text information sent and received. However, because of the risks outlined above, SPM cannot guarantee the security and confidentiality of email/text communication, and will not be liable for improper disclosure of confidential information that is not caused by SPM's intentional misconduct. Thus, individuals must consent to the use of e-mail/text communication. Consent to the use of e-mail/text includes agreement with the following conditions:
    - Although SPM will endeavor to read and respond properly to an e-mail/text, SPM cannot guarantee that any particular e-mail/text will be read and responded to within any particular period of time. Thus, no one shall use e-mail for medical emergencies or other time-sensitive matters. Please call 911 for emergencies and go to the nearest urgent care or immediate care center for urgent matters.
    - All Emails/Text to or from SPM patients concerning diagnosis or treatment will be printed out and, at the Provider's discretion, may be made a part of the patient's medical record. Because they are a part of the medical record, other individuals authorized to access the medical records, such as a staff or billing personnel, will have access to those e-mails/texts.
    - SPM may forward e-mails/texts internally to the practice's staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling. SPM will not, however, forward e-mails/texts to independent third parties without the patient's prior written consent, except as authorized or required by law.
    - If the individual's e-mail/text required or invites a response from SPM, and the individual has not received a response in a timely manner or within a business week, it is the individual's responsibility to follow up by telephone to determine whether the intended recipient received the e-mail/text and when the recipient will respond.

Patient Name:
DOB:

Spirit Point Medicine
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- Individuals should not use e-mail/text communication regarding sensitive medical information such as information regarding sexually transmitted diseases, AIDS/HIV status, mental health, developmental disability, or substance abuse.
- Individuals are responsible for informing SPM of any types of information that they desire not to be sent by e-mail/text, in addition to those called out in the above paragraph.
- The individual is responsible for protecting his/her password or other means of access to e-mail/text. SPM is not liable for breaches of confidentiality caused by the individual or any third party.
- SPM shall not engage in e-mail/text communication that is unlawfully practicing medicine across state lines.
- It is the individual's responsibility to follow up and/or schedule an appointment it warranted.

3. Communication by e-mail/text.
   To communicate by e-mail/text, patients shall:
   - Limit or avoid the use of his/her employer's computer.
   - Inform SPM of changes in his/her/their e-mail/text address.
   - Put the patient's name in the body of the e-mail/text.
   - Take precautions to preserve the confidentiality of e-mail/text, such as using screen savers and safeguarding his/her computer password.
   - Withdraw consent only by written communication to SPM.

Acknowledgement and Agreement

I understand and acknowledge that I have read and fully understood this consent form. I request and consent to SPM using email/text to communicate with me at the e-mail address(es) and/or telephone number(s) that I provide and I understand that such communications may contain my protected health information, including health history, diagnosis and treatment information and demographic information. I understand the risks associated with e-mail/text communication between SPM and me, and consent to the conditions outlined above. In addition, I agree to the instructions for communication by e-mail/text outlined here, as well as any other instructions that SPM may impose to e-mail/text communications. I understand and acknowledge that I have the right to withdraw my consent in writing at any time and that this authorization shall remain in effect until I withdraw my consent.

_____
Patient (print name)

_____ _____
Patient signature Date

_____ _____
Parent (under 18), Guardian, Responsible Party Date