HEALTH OFFERINGS, INC.
Lisa C. Smith, L.Ac., Dipl. Ac. (NCCAOM)
VA License #0121000050
PO Box 8361
Richmond VA 23226

Informed Consent for Acupuncture Treatment and Care

I, ______________________________________, hereby request and consent to the performance of acupuncture and TCM procedures within the scope of practice for acupuncture in the state of Virginia by licensed acupuncturist, Lisa C. Smith of Health Offerings, Inc. for me or the person for whom I am legally responsible. Licensed acupuncturist, Lisa C. Smith of Health Offerings, Inc. has discussed the nature and purpose of my treatment with me.

______ I understand that if I'm having a Medical Emergency I should call 911 or go to the nearest emergency room.

Treatment (please initial each):

______ I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion (heat therapy), cupping (manual therapy), Tui Na (Chinese medical massage), Chinese and Western herbal supplements, and diet and food therapy, and lifestyle recommendations.

______ I understand that acupuncture is a medical procedure performed by inserting filamentous needles through the skin.

______ I understand that I should not move while needles are being inserted, retained, or removed.

______ Acupuncture is not meant to be a substitution for standard medical care, and I agree to see my primary care physician or specialist within six months of starting acupuncture treatment.

______ I will inform Health Offerings Inc. of any and all prescription medicine I am taking. I will inform Health Offerings Inc. prior to treatment if I am currently taking a prescribed pain medication. I will not arrive under the influence of recreational drugs or alcohol.

______ I understand that acupuncture may be considered an investigative treatment in the United States. I also understand that no claims are made for acupuncture or herbs to cure any specific disease. Furthermore, I understand that all information given is for educational purposes only and that there are no guaranteed results. I do not expect Health Offerings, Inc. to be able to anticipate and explain all risks and potential complications of treatment, but to exercise her professional judgment during the course of treatment.

______ I understand there are some possible side effects of the above treatments including but not limited to temporary pain or discomfort, bruising, slight bleeding, swelling, or a temporary aggravation of symptoms known as a healing reaction which typically subsides within 24-48 hours.

______ I understand that Lisa C. Smith, L.Ac of Health Offerings, Inc. follows VA state law and uses ONLY disposable, one time use acupuncture needles.

______ I have truthfully disclosed my complete medical history regarding blood borne, contagious diseases such as HIV/AIDS and hepatitis.

______ Female Patients: I will inform Health Offerings, Inc. immediately should I become pregnant.

Female Patients: ☐ I am pregnant; ☐ I am NOT pregnant Date: ________________

General Information and Office Policies

Appointments and Cancellations (please initial each):

______ I understand that all treatments are by scheduled appointment only.

______ I understand that if I am more than 15 minutes late for my appointment I will have to reschedule.

______ I understand that if I need to change or cancel my appointment I must do so at least 24 hours in advance.

______ ***I understand that if I cancel a scheduled appointment less than 24 hours in advance, or if I don't show up for a scheduled appointment, I will be required to pay in full for the missed appointment. (The only exceptions that will be made are for sudden illness, emergency situations, or snowstorms.)***

______ I understand that Lisa C. Smith Lac. of Health Offerings, Inc. does not text or email with her patients.

______ **Payment:** I understand that payment is due at the time of service. Payment may be made in the form of Cash, Check, American Express, Discover, Visa or MasterCard. There is a $30.00 charge for returned checks.

______ **Insurance: I understand that Health Offerings, Inc. does not accept insurance as a method of payment. Health Offerings, Inc. does not file insurance claims or accept third-party insurance payments.** However, acupuncture is frequently covered by Health Savings Accounts (HSAs) and Medical Savings Accounts. The IRS recognizes acupuncture as a deductible medical expense so save your receipts if you itemize your taxes. If you plan to submit insurance claims, please contact your insurance provider for your coverage information which would include: the number of visits allowed per year, amount of the copay, if required. If you do choose to pursue reimbursement, it is helpful to obtain the applicable ICD-10 diagnostic codes

from your physician. Lisa C. Smith, L.Ac. of Health Offerings, Inc. will create a SuperBill for you to submit.

Medical Records

______ I understand that all records are secured to protect patient privacy by Health Offerings, Inc. and are confidential. My file will be kept for six years from the date of my last treatment. After this time, my records will be destroyed. No electronic records are created or available. This office follows all applicable HIPAA compliance procedures. A signed Medical Records Release form is required prior to the release of any patient records requested by courts or insurance companies, and a Consent to Confer is required between other members of the health care team prior to any confidential discussion of my case. You may submit a written request at any time to review your chart or request a copy of your medical records for acupuncture care as dictated by Virginia law. This is subject to copy fees.

______ I understand that any forms requiring more than 15 minutes to complete for insurance companies and/or attorneys/self are subject to my hourly rate billed in 10 minute increments due upon completion.

______ I have read all the above (or have had it read to me), and I have had the opportunity to ask questions regarding the above information. I agree to all the above and intend for this consent to cover the duration of all treatments unless I revoke this agreement in writing.

Patient's Name ____ Date ________________

Patient's Signature ____

Representative Party ____

(e.g. Power of Attorney, Guardian, Parent for minor - if necessary)

Acupuncturist's Name __________________________________ Date________________

Acupuncturist's Signature ____