

# ABR Acupuncture

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

---

This Consent was signed by: \_\_\_\_\_  
Printed Name - Patient or Representative

\_\_\_\_\_  
Signature

Relationship to Patient (if other than patient): \_\_\_\_\_

Date: \_\_\_ / \_\_\_ / \_\_\_

Witness \_\_\_\_\_  
Printed name - Practice representative

Date: \_\_\_ / \_\_\_ / \_\_\_

# ABR Acupuncture

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, \_\_\_\_\_  
(Patient's name)

D.O.B. \_\_\_\_\_ LAST FOUR OF SS# \_\_\_\_\_

GIVE: \_\_\_\_\_  
ABR Acupuncture/ Robert Balkind

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION REGARDING MY  
MEDICAL STATUS TO:

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Address) (Phone)

THE FOLLOWING TYPES OF INFORMATION ARE SPECIALLY AUTHORIZED FOR  
RELEASE:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

EXPIRATION DATE OF THIS AUTHORIZATION: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_  
(Patient's signature) (Date)

\_\_\_\_\_  
(Witness signature) (Date)

Our Notice of Privacy Practices provides information about our use of a patient's protected health information (PHI). The Notice contains a Patient Rights section describing your rights under the law. Patients have the right to access, inspect, and copy protected health care information used to make decisions about them.

# ABR Acupuncture

To be kept in patients chart

To: Patients Paying at the Time of Service

In an effort to minimize costs and create the best possible atmosphere for healing, we have made the following adjustments to our Usual and Customary Rates. We are able to do this because paying at time of service frees this office from time-consuming paper work and tracking of filed insurance claims.

At your initial visit, you will be responsible for the New Patient office visit. The bill will show the office visit and my fee. However, there are several procedures that may occur during your visit, which will be modified, any of these procedures used during your treatment will be reduced to \$0.00, and you will be responsible for the office visit fee only.

97810-52	Acupuncture	1 <sup>st</sup> 15 min	97813-52	Acupuncture w/Elec.stim	1 <sup>st</sup> 15 min
97811-52	Acupuncture	2 <sup>nd</sup> 15 min	97814-52	Acupuncture w/Elec Stim	2 <sup>nd</sup> 15 min
97010-52	Heat therapy		97140-52	Manual Therapy	
97014-52	Elec. Stim (Unattended)		97530-52	Kinetic Activities	
97032-52	Elec. Stim. (Attended)		97110-52	Therapeutic Exercises	
99070-52	Needles				

The fee for the New Patient office visit (code 99203) is \$ 75.00

The fee for each office visit after the initial visit (code 99215) is \$ 75.00

**I have read and understand the information contained therein.**

Date \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature

Yours in Health,

Rob Balkind L.AC  
ABR Acupuncture

# ABR Acupuncture

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation):

---

---

II. Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**:

Name \_\_\_\_\_ Phone Number \_\_\_\_\_  
Name \_\_\_\_\_ Phone Number \_\_\_\_\_

III. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

---

---

IV. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":

YES \_\_\_\_\_ NO \_\_\_\_\_

V. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number: \_\_\_\_\_

VI. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail?

YES \_\_\_\_\_ NO \_\_\_\_\_

PATIENT NAME \_\_\_\_\_ (guardian if under 18 years)

\_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

## ABR ACUPUNCTURE CONSENT TO TREATMENT

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, cupping, electrical stimulation, herbal therapy, massage, Qi Gong, and nutritional counseling.

I understand that acupuncture, electrical stimulation, cupping and pricking are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting or nerve damage. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha, or spooning. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get 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 understand that my acupuncturist may review my medical records and lab reports, but all my records will be kept confidential. If it becomes necessary to share my health information, this will be handled in accordance with the stipulations detailed in the Notice of Privacy Practices document that has been provided to me, and of which I have acknowledged receipt.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

I recognize that scheduling an appointment involves the reservation of time specifically for me, and that consequently, **a minimum of 24 hours notice is required to reschedule or cancel an appointment. Unless otherwise agreed to in advance, the full fee will be charged for sessions missed without such advance notification.** I understand that most insurance companies do not reimburse for missed sessions.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred or carried out at this practice.

---

Patient Signature

Date