Providing natural alternatives for optimum health and beyond...

Month /Day /Year

_____

Date of Initial Service

Office

13951 N. Scottsdale Rd.
Suite # 100
Scottsdale, AZ 85254
480-607-7999

Mailing Address

8711 E. Pinnacle Peak Rd.
PMB # 154
Scottsdale, AZ 85255
Cell: 480-620-7777
Email: Sunanda4health @gmail.com

ACUPUNCTURE CENTER *for* Oriental & Harmonic Medicine

Consent & Privacy Authorization

Name:_____ **Phone:**_____
Email Address: _____ **Date of Birth:**_____
Mailing Address:_____
City:_____ **State:** _____ **Zip:** _____

As required by the Privacy Regulations, *Acupuncture Center for Oriental & Harmonic Medicine, PLLC, and MindBody Medicine Center LLC* may not use or disclose your protected health information except as provided in our 'Notice of Privacy Practices' without your authorization.

I, _____, hereby authorize this Practice and any of its employees to use or disclose my Patient Health Information to the following person (s), entity, or professional colleagues for the purpose of coordinating and supporting the patient/client goals for reaching optimum health and improving the quality and results of my health services:

*Dr. Ronald Peters, MindBody Medicine Center LLC,
*Sunanda Harrell-Stokes, Acupuncture Center for Oriental & Harmonic Medicine,
*_____

Effective date for this authorization begins: __/__/_____ and continues until services are completed.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.
I understand I have the right to:

1. Revoke the authorization by sending written notice to:
   Acupuncture Center for Oriental & Harmonic Medicine PLLC and
   MindBody Medicine Center LLC
   and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Have knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient/client health information.

Patient/Client Name (print): _____
Patient /Client Signature: _____ Date: _____

(Patient / Client or Authorized Representative)

Acupuncture Center *for* Oriental & Harmonic Medicine

I, _____, give my consent to have acupuncture procedures, Acutonics, Acutron Micro-current, LIFE Systems Biofeedback, and Kita Peace Machine Sound Healing administered as a part of my service sessions.

Acupuncture and the Principles of Traditional Chinese Medicine (TCM) have been practiced for more than 2,500 years and used effectively in various forms by more than one-fourth of the world's population (China, Korea, Japan, and many other Asian and European countries).

I understand that there is no implied or stated guarantee of success of a specific procedure, treatment, or series of treatments herein authorized by me, and there are no guarantees that Acupuncture will cure my condition. The focus of the work is to encourage a balance in the natural energy flow of the body, based upon 'TCM' diagnostic techniques.

I understand that the Acupuncture treatment, Acutonics®, Biofeedback, Kita Peace Machine Sound Healing, Micro-current, and herbal consultations are all performed by a state licensed and nationally certified practitioner of Oriental Medicine and are not performed by a medical doctor.

The procedures associated with the principles of 'TCM' consists of diagnostically feeling the pulse, observing the tongue, and palpating areas on the abdomen in order to determine the patterns of imbalance. The practitioner may use a of modalities to re-establish a balance in the energetic flows.
Acupuncture involves the insertion of fine, pre-sterilized stainless steel needles into the skin at various acupuncture points.
Acutonics® uses precision calibrated tuning forks to deliver a specific frequency into the point, a form of 'needless' acupuncture.
LIFE Systems Biofeedback uses light diodes in contact with specific acupuncture points thereby providing an energetic assessment and intervention using biofeedback and bio-resonance to stimulate the body's own healing mechanisms.
Kita Peace Machine Sound Healing introduces specific balancing frequencies through a dual delivery system: auditory via head phones and by the application of a transducer to the larger meridian pathways.

When applicable, treatment may also include the use of one or more of the following: Acutonics®, acupressure, Moxibustion (a warming herb placed above the surface of the skin), the application of Chinese herbs, foods, or supplements to the skin surface in the form of a poultice, plaster, or in a moisturizer base, electro-stimulation, TDP (far– infrared heat Lamp), cupping with glass jars, Gua Sha (scrapping of the skin), ear beads, tacks, or magnets.

I understand that there may be some discomfort at the time of needle insertion. This will pass quickly. Occasionally some light-headedness may occur. This is more common if one is very hungry and /or tired. In addition, with needling, superficial capillaries may rupture causing local bruising and slight bleeding when the needle is withdrawn.

Only sterile, disposable needles are used, and infections are rare. I agree to let the acupuncturist know if I am experiencing any discomfort. The acupuncturist can easily make adjustments to my treatment needs. I am aware that there may be temporary aggravation of pre-existing symptoms in the healing process.

I understand that a minimum of 24 hours notice is required for cancellation or re-scheduling of appointments. This allow others who may be waiting for an appointment time to be contacted and re-arrange their schedule. A broken appointment fee will be charged to my account, and is payable by me if 24 hours notice is not given. I realize that I may discontinue treatment at any time. I hereby certify that I have read the above statement, have had my questions answered to my satisfaction, understand the provisions described herein, and do hereby give consent for treatment.

Client Name (print):_____ _ **Date of Birth:** _____ _ **Age:** _____

Signature:_____ **Date:** _____ **Phone:** _____

Provider Statement: I certify that I have informed the above-mentioned client of the following: the nature, purpose, and possible consequences of the procedure, risks involved, possibilities of complications and alternatives.

Provider Signature: _____ _____ **Date:**_____