**Office Terms and Conditions of Service**

24-Hour Cancellation Policy: In order to provide you and patients like you with the highest standards of care, all cancellations must be made within a minimum of 24 hours notice. Failure to do so or failure to show for your scheduled appointment will result in your credit card account being charged up to 100% of the appointment fee.

Admissions and Medical Services Agreement: The patient or the patient’s representative consents to the admission of the patient to Dr. Ashley Tomasino, LAc, CMT if this is deemed necessary for the care of the patient. All the terms and conditions hereof shall also apply to such admissions.

Release of Information: Dr. Ashley Tomasino, LAc, CMT is authorized to furnish from the patient’s record necessary information to the referring physician, if any, and to others to the extent required in connection with a claim for aid, insurance, or medical assistance to which the patient may be entitled.

Medical Records: The patient or patient’s representative hereby authorizes Dr. Ashley Tomasino LAc, CMT to obtain his/her medical records from previous medical histories rendered by other physicians or medical centers.

Financial Agreement: The patient or patient’s representative shall pay Dr. Ashley Tomasino, LAc, CMT for all services rendered in accordance with the regular rates and terms of Dr. Ashley Tomasino, LAc, CMT. When this agreement is executed by the patient or the patient’s representative or a financial guarantor, all shall be jointly and individually liable for the patient, whether or not the patient’s insurance company pays. Should accounts be referred to an attorney or collection agency, I agree to pay all collection costs, court costs, and attorney’s fees in addition to the fees for services rendered.

**Informed Consent**

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of the 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 below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese Massage), massage, Chinese Herbal Medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the tea consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

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 a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although this clinic uses single-use sterile disposable needles as per California State law, and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate in during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able 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 the 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 releases 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 and Terms and conditions of Service, 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.

Patient’s or Patient’s Representative Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Consent for Use and Disclosure of Protected Health Information**

With my consent, Ashley Tomasino, LAc, CMT may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Ashley Tomasino, LAc, CMT Health Information and Privacy Policy (HIPP) for a more complete description of such uses and disclosures.

I have reviewed and received a copy of the HIPP prior to signing this consent. Ashley Tomasino, LAc, CMT reserves the right to revise its HIPP at anytime without notice to me. A revised HIPP may be obtained by submitting a written request to Ashley Tomasino, LAc CMT.

With my consent, Ashley Tomasino, LAc, CMT may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any information pertaining to my clinical care.

With my consent, Ashley Tomasino, LAc, CMT may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Ashley Tomasino LAc, CMT may email to me appointment reminder cards and patient statements. I have the right to request that Ashley Tomasino LAc, CMT restrict how it uses or discloses my PHI to carry out TPO. However, Ashley Tomasino, LAc, CMT is not required to agree to my requested restrictions.

By signing this form, I am consenting to Ashley Tomasino LAc, CMT use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Ashley Tomasino, LAc, CMT may decline to provide treatment to me.

**Health Information and Privacy Policy (HIPP)**

This notice describes Ashley Tomasino LAc CMT’s policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share personal medical and financial information with your insurance company, with worker’s compensation (and your employer as well in this instance), or with other medical practitioners or others that you authorize.

Safeguards in place at Ashley Tomasino, LAc CMT include:

* Limited access to facilities where information is stored
* Policies and procedures for handling information
* Requirements for third parties to contractually comply with privacy laws
* All medical files and records are kept on permanent file

In administering your health care, we gather and maintain information that may include non-public personal information

* About your financial transactions with us (billing transactions)
* From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners concerning your healthcare
* From healthcare providers, insurance companies, workers’ compensation and your employer, and other third party administrators (e.g. request for medical records, claim payment information).

We here, at Ashley Tomasino, LAc CMT, value our relationship with you and respect your privacy. If you have any questions about our privacy guidelines, please call us during regular business hours.

Thank you for placing your trust in us.  
By voluntarily signing below, I show that I have reviewed and received a copy of Ashley Tomasino, LAc CMT’s HIPP.

Patient’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Signature of Patient/Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\* PATIENT COPY\*\* Health Information and Privacy Policy (HIPP)**

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* From healthcare providers, insurance companies, workers’ compensation and your employer, and other third party administrators (e.g. request for medical records, claim payment information).

Ashley Tomasino LAc, CMT values your relationship and respects your privacy. If you have any questions about our privacy guidelines, please call us during regular business hours.

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Signature of Patient/Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_