NOTIFICATION FORM REGARDING EVALUATION OF PATIENT BY PHYSICIAN

(Pursuant to the requirement of section 183..7 (e) of this title and section 6.11, Subsection (d) V.A.C.S article 4495b, governing the practice of acupuncture)

I (patient's name), _____
am notifying Element 5 OM of the following:

☐Yes ☐No I have been evaluated by a physician or dentist for the condition being treated within twelve (12) months before the acupuncture was performed. I recognize that a physician or dentist should evaluate me for the condition being treated by the acupuncturist.

OR

☐Yes ☐No I have received a referral from a chiropractor within the last 30 days for acupuncture. The date of the referral is _____ , and the most recent date of chiropractic treatment prior to acupuncture treatment is _____ . After being referred by a chiropractor, if after 60 days or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice to follow this advice.

OR

I have not been evaluated by a physician or dentist for the condition being treated, nor have I received a referral from a chiropractor, but I seek treatment for symptoms related to one or more of the following conditions:

- ☐ Chronic Pain
- ☐ Smoking Addiction
- ☐ Weight Loss
- ☐ Alcoholism
- ☐ Substance Abuse

_____
Signature

_____
Date

The acupuncturist has referred me to a physician. It is my responsibility and choice to follow his/her advice.

_____
Signature

_____
Date

_____
Acupuncturist Signature

CANCELLATION POLICY

We are a small boutique treatment center for Acupuncture & Herbal Medicine. Therefore during busy times space is limited. When you reserve a time with us, we not only guarantee your appointment and service length, we are also turning away others who might want your spot. Our patients receive confirmation emails approximately 48-hours before the scheduled appointment.

24-Hour Cancellation Policy –
In order to provide you and other patients with excellent customer service and access to appointments during peak times, please call us (713) 942-7110 with 24-hours notice if you need to reschedule or cancel. Please be sure to leave a message if we are unavailable. Additionally you have the option of rescheduling or canceling online through our website, www.element5om.com.

Same-Day/Emergency Cancellations –
We understand that sudden illnesses, emergencies or things just sometimes come up. If less than 24-hours notice is given we will only require a credit card to reserve your next appointment. If you keep all future appointments there will never be any additional charges. You will be able to pay for your services as usual with your choice of Visa, MasterCard, Discover. check or cash. In the instance of a second "same-day" cancellation or reschedule your credit card will be charged only 50% of the missed service, but only if we are unable to book another patient in your time slot.

No Shows –
If you fail to appear for your appointment without attempting to cancel your appointment beforehand the full fee will be charged to your credit card or you will forfeit the full value of your gift certificate or voucher.

Late Arrival –
Arriving late will simply limit the time for your treatment. Your treatment will end on the regularly scheduled time so that the next patient will not be delayed.

By signing this form I acknowledge that I have read, or it has been read to me, and I fully understand the cancellation policies and will abide by them.

_____
Signature

_____
Date

INFORMED CONSENT TO ORIENTAL MEDICINE HEATH CARE

I hereby request and consent to the performance of acupuncture and other Traditional Chinese Medicine (TCM) treatments on me (or on the patient named below, for whom I am legally responsible) by the licensed acupuncturists who now or in the future treat me while on staff with Element 5 OM.

I understand that the scope of the practice under Element 5 OM includes but is not limited to: acupuncture, herbal therapy and other oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle, and orthopedic testing; modes of manuals or physical therapy such as massage, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation; the prescription of herbal and homeopathic medicines as well as dietary supplements and dietary recommendations, exercise, discussion and advice regarding thoughts, feelings, sensations, emotions and attitudes, and healthy life style counseling.

I understand and am informed that, as in the practice of allopathic medicine, in the practice of Oriental Medicine there are some risks with treatment. I understand that although the risk of avert side effects are extremely minimal, they are possible. This could include, but are not limited too: bruising, bleeding, skin irritation, pain in the treated area, muscle weakness and soreness, brief generalized fatigue or nausea, sensations of heat or cold, tingling or numbness, brief lightheadedness or fainting, broken needles and risks of infection or pneumothorax, and the possible aggravation of symptoms existing prior to acupuncture treatment or creation of new symptoms. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

By signing this consent form I acknowledge that I have read this informed consent form, or it has been read to me, and I fully understand the nature, purpose and risks of acupuncture and other oriental medical procedures. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications associated with treatment at Element 5 OM. I wish to rely on my acupuncturist and their judgment in my best interest, based on the facts I have given them, during the entire course of my treatment. I have had an opportunity to ask questions about this form's content, and by signing below I agree to the named procedures. I intend this consent form to cover the entire course of treatment for my present and any future conditions for which I seek treatment at Element 5 OM.

HIPAA AND PRIVACY PRACTIES

A record is made each time you visit this clinic. Your symptoms, the acupuncture's judgment, and a plan of treatment are recorded. This record serves as a basis for planning your care and treatment at future visits. Your health record is the physical property of this clinic, but the content is about you, and therefore belongs to you. You have the right to review or obtain a paper copy of your health record. You have the right to request restrictions on certain uses and disclosures of your information. By signing this consent form you agree that you may be contacted by staff members in regards to appointments or information related to treatments. If this contact is unavailable by phone, the staff member may leave a message with an answering machine or anyone who answers the phone.

This clinic is required to maintain the privacy of your health information with this notice of our privacy practices. We are required to follow the terms of this notice and to notify you if we are unable to grant your request to disclose or restrict disclosure of our health information to others. Other than for the reasons described in this notice, this clinic agrees not to use or disclose you health information without your authorization.

By signing this consent form I acknowledge that I have read, or it has been read to me, and I fully understand the Privacy Practices regarding disclosure and patient health information.

_____

Signature

_____

Printed Name

_____

Signature of Patient's Representative

_____

Printed Name of Patient's Representative

_____

Relationship or Authority of Patient's Representative

_____

Date Signed