INFORMED CONSENT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or the patient named below, for who I am legally responsible) by the acupuncturist named below.

I understand the methods of treatment may include, but are not limited to, acupuncture, moxibustion, craniosacral therapy, cupping, gwasha, electrical stimulation, tuina (Asian massage), Chinese herbal medicine, lymphatic drainage and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify the acupuncturist 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. Transitory redness on the skin, called petechia, is a therapeutic effect of cupping and gwasha that lasts a few days post treatment. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile, disposable needles 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 nutritional 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 high doses. I understand that some of the herbs may be inappropriate 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 the clinical staff 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 acupuncturist will review my patient records and lab reports, but all my records will be kept confidential and will not be released without my consent. By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, 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 Signature **DATE**

_____

Renée Hahn, Doctor of Acupuncture and Chinese Medicine, Licensed Acupuncturist **DATE**

Notice of HIPAA Privacy Practice

The following notice describes how health information about you may be used and your rights regarding the use of health information. Please review this notice carefully.

Renée Hahn, Licensed Acupuncturist, Diplomate of Oriental Medicine (NCCAOM), understands that information about you and your health is personal. I am committed to protecting your health information, and keeping it in full confidence.

You have the right to:
* Ask to see, read, and/or obtain a copy of your health record (charges may be necessary).
* Ask to correct information you believe is wrong in your health record.
* Ask that information not be shared with certain individuals.
* Ask that your information not be used for certain purposes; for example, research.
* Ask me to send copies of your health record to whomever you wish (charges may be necessary).
* Be informed about who has read your record (for reasons other than treatment, payment and practice improvements).
* Specify where and how I may contact you.
* Receive a paper copy of the full Notice of Privacy Practices.

Written Authorizations
To use or disclose PHI, you will need to sign a written authorization prior to access or disclosure. Refer to the "Notice of Privacy Practices" for a list of covered exceptions to the authorization requirement related to public policy, certain health disease reporting requirements and law enforcement activities. (Available as of April 4, 2003 at http://www.ucsf.edu/hipaa.) If you do not know or understand what you can do with PHI, please read "Notice of Privacy Practices".

Exceptions to the Rules
Under HIPAA, there are certain exceptions to these general rules. These exceptions are described in the "Notice of Privacy Practices". Disclosures can be made without patient authorization: subject to professional judgment, for public health and safety purposes, for government functions, law enforcement and based on a judicial request or subpoena. If you believe your rights have not been maintained you may file a complaint with the secretary. The address is: U.S. Dept. of Health and Human Services, Office of Civil Rights, Attn: Regional Manager, 50 United Nations Plaza, Rm. 322, San Francisco, CA 94103. You will not be penalized in any way for filing a complaint.
I acknowledge receipt of the "Notice of Privacy Practices" and "Patient Rights". I understand that my signature does not authorize disclosure but only acknowledges that I have received a copy of the full Notice.

SIGNATURE:_____DATE:_____

DATE OF BIRTH:_____

PRINTED NAME:_____