Academy for
Five Element Acupuncture

SCHEDULING AND PAYMENT POLICIES

Our goal is to provide the best possible medical care in a timely manner. Should you need to cancel or rescheduled an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Our Appointment Cancellation/No Show Policy is described below.

APPOINTMENT CANCELLATION and "NO SHOWS"
We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" schedule. A "no show" is someone who misses an appointment without canceling it within 24 hours or more in advance, and the appointment is considered "unattended".

HOW TO CANCEL AN APPOINTMENT
If it is necessary to cancel your appointment, we require that you call or email no later than one day in advance (24 hours). Call the clinic line at 352.548.2332 or email at clinic@acupuncturist.edu. If you do not reach the receptionist by phone, please leave a detailed message. If you would like to reschedule your appointment, let us know and we will return your call with the next available appointment time. Appointments must be cancelled with the clinic reception desk, not an individual practitioner.

UNATTENDED CLINIC APPOINTMENT
A fee of $25 will be charged for any appointment unattended by the patient unless the appointment was cancelled 24 hours+ of the scheduled visit.

APPOINTMENT REMINDERS
Our clinic provides text message and voice message appointment reminders. We ask that you not rely solely on this service for remembering your appointment. The responsibility of attending and cancelling appointments still rests with you, but we do hope this will make things easier.

NEW PATIENT APPOINTMENTS
The first ACUPUNCTURE appointment is a detailed intake, diagnosis and physical examination. This takes a full two hours. Acupuncture needles and often moxibustion are used in subsequent visits. In order for your initial visit to be worthwhile and effective, and because we are a teaching clinic, we ask patients to commit to an intake appointment plus two subsequent acupuncture treatments.

The first CHINESE HERBAL MEDICINE appointment is a detailed intake, diagnosis and herbal prescription. The cost of herbs is additional to the charge for your visit

PAYMENT OF SERVICES
We collect payment for professional service at the time of your appointment. Credit card payment is preferred. There is no refund for unused treatments purchased as a treatment package (i.e. 3 for $100) and all treatments must be used within one calendar year from the date of purchase.

APPOINTMENT TIMES

We make every possible effort to begin appointments at the scheduled time. Please be punctual. We understand that delays can happen, however, we must try to keep the other patients and practitioners on time. If you are running late, please notify the clinic. If a patient arrives 15 minutes or more past the scheduled time, we may have to reschedule the appointment.

Due to our nature as a teaching clinic, the duration of appointments and appointment schedule changes throughout our academic year. The appointment times can vary from 120-75 minutes in the acupuncture clinic, and 120-60 minutes in the herbal clinic. Our clinic sends out email updates when these schedule transitions occur so you can continue your course of treatment without interruption.

CURRENT APPOINTMENT FEES

ACUPUNCTURE CLINIC
Master's program students provide supervised acupuncture care. (90-120 minutes).
$50 Initial Visit
$40 Treatments
$110 Package of 3 Treatments (excludes Initial Visit)

CHINESE HERBAL MEDICINE
Master's program students develop customized Chinese herbal formulas (60-120 minutes)
$50 Initial Visit*
$40 Treatments*, plus cost of herbs
$110 Package of 3 Treatments (excludes Initial Visit)

***For patients receiving care in both clinics, we offer a reduced rate for the Chinese Herbal Medicine clinic:**
$25 Initial Visit
$25 Treatments, plus cost of herbs

STUDENTS AND VETERANS
We offer a student and veteran rate for the Acupuncture and Chinese Herbal Medicine clinics. A valid student ID is required.
$30 All visits, plus cost of herbs

COMMUNITY ACUPUNCTURE CLINIC
We offer a weekly, community style, auricular acupuncture clinic. This clinic is free for veterans and their families. For all others, we offer this service for a sliding scale fee $5-$15.

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Five Element Acupuncture

PATIENT INFORMATION

Last Name	First Name (Legal)	Middle Initial	Preferred Name

Today's Date	DOB	Legal Gender (*see note at bottom) ☐ M ☐ F	Pronouns

Street Address	City	State	Zip

Cell Phone	Work Phone	Best # to reach you

Email	How did you hear about us?

Occupation	Who may we thank for referring you?

EMERGENCY CONTACT

Name of relative or friend to contact in an emergency	Relationship to you

Cell Phone	Work Phone

IMPORTANT EMAIL NOTIFICATIONS

Due to our nature as a teaching clinic, the duration of appointments and appointment schedule changes throughout our academic year. The appointment times can vary from 120-75 minutes in the acupuncture clinic, and 120-60 minutes in the Chinese herbal clinic. Our clinic sends out email updates when these schedule transitions occur, as well as other clinic service updates, so you can continue your course of treatment without interruption.

By signing below, you consent to receive clinic updates and notifications by email.
Your email address is protected health information and will never be sold to a third party.

Patient Signature	Date Signed

Guardian Signature (if minor patient)	Date Signed

** While the Academy recognizes a variety of gender identities, many insurance companies and legal entities do not. The name/gender you have listed must be the name used on documents pertaining to insurance billing and correspondence. If your preferred name and pronouns are different from these, please let us know.*

The Academy does not offer insurance billing services.
Please let us know if you would like a printed superbill generated at your appointment time.

Academy for
Five Element Acupuncture

LIST OF MEDICATIONS

Patient Name _____ DOB _____ ☐ Initial Date _____

☐ Update Date _____

List all tablets, patches, inhalers, drops, liquids, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like Viagra, nitroglycerin).

Medication (brand and/or generic name)	Dose	How often do you take this medicine?	Reason for taking	Started when?	Stopped when?	Who prescribed it?

Check here if using additional pages ☐

Intern signature _____

Academy for
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ACUPUNCTURE AND CHINESE HERBAL MEDICINE
INFORMED CONSENT TO TREAT

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 on the patient named below, for whom I am legally responsible) by the acupuncturist indicated 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, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling.

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. Burns and/or scarring are a potential risk of moxibustion and cupping. 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 the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that the herbs may need to be prepared and the teas consumed according to the instructions providedorally and in writing. The herbs may have 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 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 large doses. I understand that some 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 a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, 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 released without my written consent.

I voluntarily permit my intern practitioner to submit my treatment sheets to Academy personnel for purposes of recordkeeping and academic instruction. I understand that a coding system is used so that my full name is not includedon forms used for academic instruction. I have been informed that I may stop treatment at any time. By signing this form, I am acknowledging that I have received and accept the terms of HIPAA Privacy policies, Payment of Services, Cancellation of Appointment and Unattended Clinic Appointments.

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.

Acupuncturist Name	Misti Oxford-Pickeral	Acupuncturist Signature	Misti Oxford-Pickeral
Patient Name (Print)			DOB
Patient Signature			Date Signed
Guardian Signature (if minor patient)			Date signed

Academy for
Five Element Acupuncture

APPOINTMENT REMINDER AUTHORIZATION

Our clinic provides text message and voice message appointment reminders. We maintain the confidentiality of your information while using this system. We will NOT send out any texts unless you have explicitly consented, and text/voice call messages will be for appointment reminders only. We ask that you not rely solely on this service for remembering your appointment. The responsibility of attending and cancelling appointments still rests with you, but we do hope this will make things easier. Please indicate below the best way to reach you for appointment reminders. You may choose more than one, however, if all are initialed you could receive up to three reminder messages.

_____
(Initial)

TEXT MESSAGE

Yes, I authorize Academy for Five Element Acupuncture to send appointment reminders electronically via text message to my cell phone. I understand that this service Is offered free of charge, however, standard text messaging rates from my mobile carrier may apply. I will receive a text reminder 24 hours before the scheduled appointment.

Cell/Text Message Number: _____

I will contact the clinic immediately with any change in my cell phone number.

_____
(Initial)

VOICE MESSAGE

Yes, I authorize Academy for Five Element Acupuncture to send appointment reminders electronically via voice messaging. If I am unavailable to answer the telephone, I give the Academy permission to leave a message on my answering machine or with the person answering the telephone. I will receive a reminder 24 hours before the scheduled appointment.

Voice Message Number: _____

I will contact the clinic immediately with any change in my voice message number.

_____
(Initial)

EMAIL CONTACT

Yes, I authorize Academy for Five Element Acupuncture to send appointment reminders electronically to the email address listed here. I will receive an email one week before the scheduled appointment time and a second email 36 hours before the scheduled appointment time. (The Academy is unable to vary this).

Email address (please print clearly): _____

I will contact the clinic immediately with any change in my voice message number.

Patient Name (Print)	DOB
Patient Signature	Date Signed
Guardian Signature (if minor patient)	Date Signed

Academy for
Five Element Acupuncture

INFORMED CONSENT TO TELEHEALTH

To better serve the needs of patients, our services may be available by telehealth (two-way interactive video communication and electronic transmission). This consent explains telehealth care. If you have any questions, please ask your provider.

I understand that I may be evaluated and treated via telehealth and agree to the following:

TELEHEALTH SERVICES
Telehealth involves transmission of video or digital photographs of me, and/or details of my health ("Transmitted Data"). All Transmitted Data is sent via electronic means to my provider(s) to facilitate health care services. I understand that:

- Telehealth is different from traditional care in that the patient and provider do not meet physically in-person;
- Patients will be informed of any additional personnel that are to be present, seen or unseen, during the encounter. Patients must inform their Provider of any person other than the patient who is present. Patients have the right to exclude anyone from either location;
- Patients have the right to refuse or stop participation in telehealth services at any time and request an in-person appointment, however, equivalent in-person services might not be available at the same location or time as telehealth services. A refusal to participate in telehealth will not affect rights to future care or benefits to which a patient may otherwise be entitled;
- Patients have the right to follow-up with their provider as necessary with questions or concerns;
- Benefits of telehealth include that the patients and providers can continue health care services when an in-person appointment is not possible or is inconvenient. The provider can also visualize some of the client's environment. Telehealth may also minimize exposure to illness;
- There are also risks involved in telehealth including, without limit, losing the ability to; a) perform aspects of a physical examination (for example listening to the patient's heart and lungs or verifying vital signs); b) read physical or vocal cues/tones, and facial expressions; and c) provide immediate emergency physical services/care;
- Additionally, technical issues may disrupt the visit. There are also risks to preserving confidentiality including the risk that communications may be overheard; and that communications may be accessed by unknown third-parties; 8) Patients shall have to access to all medical information resulting from the telehealth services as provided by applicable law for patient access to medical records.

CONFIDENTIALITY
All confidentiality protections required by law or regulation will apply to my care. Although confidentiality extends to communications by text, email, telephone, videoconference and other electronic means, providers cannot guarantee that those communications will be kept confidential and/or that a third-party may not gain access to such communications.

With electronic communication, there is always a risk that communications may be compromised, unsecured, and/or accessed by a third-party. To help maintain confidentiality when engaging in electronic health services, it is important that all sessions be conducted in a confidential place. This means that clients agree to participate in telehealth only while in a room or area where other people are not present and cannot overhear the conversation. Do not have sessions in public places. Sessions may not be recorded and patients must seek written permission before recording any portion of the session and/or posting any portion of sessions.

EMERGENCIES
Telehealth is not appropriate if I am experiencing an emergent health care situation. If am experiencing an emergency, I understand that it is my responsibility to immediately call 911. If an emergency develops during telehealth services, I understand that it is my responsibility to immediately inform my telehealth provider, call 911 and stay connected with my telehealth provider (if possible) until help arrives.

I have read and agree to the terms in the Telehealth Consent. I understand that telehealth is not a substitute for in person health care services. I understand that telehealth is not appropriate if I am experiencing a crisis or having suicidal or homicidal thoughts. In case of emergency situations, I will contact 911.

Patient Name (Print)	DOB
Patient Signature	Date Signed
Guardian Signature (if minor patient)	Date signed

PRIVACY POLICY

As providers of your care, we have developed certain practices to help protect your health information. In general, our Privacy Practices describe how, when and why we may use and disclose your health information, as well as your rights with regard to your health information.

YOU ARE ENTITLED TO RECEIVE AND REVIEW OUR FULL LENGTH LEGAL NOTICE OF PRIVACY PRACTICES, AVAILABLE AT OUR OFFICE, ON OUR WEB SITE AT acupuncturist.edu, OR BY CALLING 352.335.2332

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), provides certain protections for any health information that can be specifically identified as yours. HIPAA permits and our Privacy Practices allow us to use your individually identifiable health information or to share it with another health care provider or an insurance company in the following circumstances:

- To treat and care for you, including contacting you for appointment reminders and follow-up care;
- To obtain payment from you or your named insurance company;
- Administrative and clinical office procedures designed to optimize scheduling and coordination of care among our teachers, staff, and students;
- In connection with our clinic or academic operations which typically include teaching, training and review for students and staff, business planning, customer service, grievance resolution, and other general administrative activities.

HIPAA also allows us to use certain health information for the following activities:

- Fund-raising purposes;
- When required by law;
- Possible abuse, neglect or domestic violence;
- Public health and safety and national security;
- Audits, certifications, licensing, accrediting or credentialing activities related to quality assurance and compliance reviews;
- Law enforcement related to its criminal investigations;
- Judicial and administrative proceedings;
- Research (provided other precautions are taken regarding your information).

If our use or disclosure is not for one of the activities described above and is not otherwise permitted under HIPAA, we will ask you to complete a written authorization before we use or release your health information.

The authorization will:

- Describe in detail the health information it covers;
- Identify to whom your health care information will be released and how it will be used;
- Describe when it will be used or released; and finally
- State the expiration date.

When receiving services from us, you will also be able to decide whether we can discuss your health information with your family or friends.

Even if you have provided us with your authorization, you may withdraw that authorization, in writing, at any time to stop our future disclosures of your health information. Information disclosed before you revoked your authorization will not be returned and any actions that we have already taken based on prior authorizations will not be affected.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Restricting a Use/Disclosure
You may request a restriction on how we use or disclose your health information. We are not required to agree to your request and any approved restriction may only be followed to the extent permitted by law.

Requesting Confidential Communications
You may request reasonable changes in how or where we may contact you to remind you of an appointment or provide other health information.

Inspecting and Obtaining Copies of Your Health Information
You may ask, in writing, to look at and/or obtain a copy of your health information. There may be a fee associated with your request.

(Cont. Page 2)

PRIVACY POLICY

Requesting a Change in Your Health Information
You may request, in writing, a change or addition to your health information. The law limits the types of changes that may be made and we may not erase or delete any information in your records.

Requesting an Accounting of Disclosures of Your Health Information
You may ask, in writing, for an accounting of certain types of disclosures made of your health information. Disclosures made with your authorization will not be included in the accounting. We may need to charge you a reasonable fee for your request.

Obtaining a Notice of Our Privacy Practices
Our Notice explains and informs you of our Privacy Practices. You may obtain a copy of our Notice as described above. We welcome an opportunity to address any questions or concerns that you may have regarding the privacy of your health information.

If you believe that the privacy of your health information has been violated, you may contact us to discuss your concern or to file a complaint. Please contact our Privacy Officer by calling 352.335.2332 or by writing 305 SE 2nd Avenue, Gainesville, FL 32601. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services.

You will not be penalized or retaliated against for filing a complaint or voicing a privacy concern.

WHAT IS YOUR HEALTH INFORMATION?

According to the HIPAA law, your "Protected Health Information" is any information about you that can identify you. This includes your health records and such things as your name, telephone number, address, and dates such as your birthday, start of treatment and appointments.

MORE INFORMATION ABOUT HOW YOUR HEALTH INFORMATION MAY BE USED

For Law Enforcement
As permitted or required by State or Federal Law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including under certain limited circumstances, if you are the victim of a crime or in order to report a crime.

Family, Friends, Caregivers
We may share your health information with those you tell us will be helping you with your care. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our very best judgment and will share your health information only when it will be important to those participating in providing your care.

Medical Research
Advancing medical knowledge often involves learning from the careful study of the medical histories of prior patients. Formal review and study of your health history as a part of a research study will happen only under the ethical guidance, requirements, and approval of an Institutional Review Board.

Authorization to Use or Disclose Health Information
Other than what is stated above, or where Federal, State or Local law requires it, we will not disclose your health information except with your written authorization. You may revoke that authorization in writing at any time.