

NATURAL HEALTHCARE CENTER

Shaoyun Liu L.Ac, C.M.D

HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge consent for use and disclosure of PHI and receipt of this Notice of Privacy Practices.

FINANCIAL POLICY

I have read and understand the above information. I understand I am responsible regardless of my insurance for any and all charges incurred from service provided

APPOINTMENT POLICY

Any questions I have concerning my appointments have been answered. I have read this statement and fully understand it.

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity ask questions. I intend this consent form to cover the entire course of treatment for my present and for any future condition(s) for which I seek treatment.

Print Name: _____ Date: _____

SIGNATURE: _____

OFFICE USE ONLY:

I attempted to obtain the patient's signature on this HIPAA Notice of Privacy Practices, Financial Policy, Appointment Policy, Informed Consent For Acupuncture Treatment And Care, But was unable to do so as documented below:

Date: _____ Initial: _____

Reason: _____