Heidi von Brockdorff, Dipl. OM, L. Ac.
1400 Executive Pkwy, #245
Eugene, OR 97401
970-250-0940

Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica. I understand that acupuncturists practicing in the state of Oregon are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by Heidi von Brockdorff.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perceptions, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, pneumothorax, skin infection, and risk of spontaneous miscarriage, and the possible aggravation of symptoms existing prior to acupuncture treatment. ***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.***

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, **there is a risk of burning or scarring from its use.** I understand I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I decide to take them. *I am aware that certain adverse side effects may result from taking these substances.* These could include but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call Heidi von Brockdorff at 970-250-0940 as soon as possible.*

Acupressure/Tui Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. **I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.**

Signature:_____ **Date:**_____

Printed Name:_____

Date of Birth:_____

Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Phone Number:_____

Patient required more detailed explanation about the following:_____

_____

_____

The following response was given:_____

_____

_____

Patient Signature confirming response;_____

Provider Initials:_____ Date:_____

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FINANCIAL POLICY

I offer several methods of payment for your acupuncture treatment and you may choose the plan which best suit your needs. Please read carefully and choose the plan that you prefer. This information will enable us to better serve you and help us to avoid misunderstandings in the future.

PLAN ONE:
The **self-pay** plan means that all fees will be paid when service is rendered. Fees are discounted for payment at the time of service.

PLAN TWO:
If you have **insurance**, I will bill for you as a courtesy. Payment for deductibles, if it has not been met is the responsibility of the patient as well as any copayment or remaining balance after insurance payment. I do participate in many insurance plans that may allow nominal out of pocket expense. **You co-pay is due as services are rendered.** You are also responsible for portions of your bill that exceed your insurance limits.

Credit Cards are accepted for all or partial payment.

If care is discontinued, the balance for care received up to that date is due in full in 30 days.

I, _____ understand that all responsibility for payment of services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. I permit this office to endorse co-issued remittances for the conveyances of credit to my account. In the event payments are received by the agreed upon dates, I understand that a 1.5% finance charge (18% APR) will be added to my account. I agree to pay all attorneys and collection fees if this account is turned over to collection.

PLEASE ADVISE WHICH PLAN YOU WOULD LIKE TO USE:_____
Please sign below to indicate your understanding of my financial policies. If you do not understand, please allow me to review the policies with you until they are clear.

_____Date:_____
Patient Signature

_____
Print Name

_____Date:_____
Witnessed by:

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE **X**

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

Heidi von Brockdorff, L.Ac Protects Your Health Information and Privacy

Dear Valued Patient,

This notice describes our office'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 limited 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 that you authorize.

Safeguards in place at our office 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 (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:

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 text messages, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (e.g. requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you – e.g. your name, address, Social Security number, etc.).

We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at (970) 250-0940.

Yours truly,

Heidi von Brockdorff, Dipl. OM, L.Ac.
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