



## HIPAA Notice of Privacy Practices and Consent/Written Acknowledgement

I hereby consent to the use and disclosure of my protected health information by Inez Coppola, LAc for the purposes of **treatment, payment and healthcare operations**, or as otherwise required by law.

- I acknowledge that Inez Coppola, LAc has provided me with a copy of Notice of Privacy Practices which describes how medical information about me may be used and disclosed, and how I can access this information. I have a right to review the Notice of Privacy Practices prior to signing this consent and to receive a printed copy of the Notice of Privacy Practices.
- I have the right to request restrictions to the usage and disclosure of my protected health information.
- I have the right to request an alternative to the standard method of communication of my protected health information.
- I understand that if I wish to revoke this consent at any time I will do so in writing and submit to the address listed below. I understand that while Inez Coppola, LAc may honor these requests, they are not required by law to do so. I also understand that revocations will be honored as of the date they are received by Inez Coppola, LAc.

I understand that if I have any questions or complaints I may submit them in writing to the address above or contact Inez Coppola, LAc by phone at: **(509)596-1074**

I am aware that Inez Coppola, LAc reserves the right to change the terms of Notice of Privacy Practices and to make new notice of Privacy Practices provisions effective for all protected health information that they maintain. In the event of amendments, Inez Coppola, LAc will make available a revised Notice of Privacy Practice for my review.

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Patient (18 years or older)

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Date

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Parent, Guardian, Responsible Party

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Date

## **Notice of Privacy Practices**

**THIS NOTICE DESCRIBES HOW HEALTH CARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

**Uses and Disclosures of Protected Health Information** Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital administration.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of health care students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to health care students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

**Use required by Law:** We may use or disclose your protected health information in the following situations without your authorization. These situations include; as Required by Law, Public Health issues as required by law, Communicable Diseases; Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners: Funeral Directors, and Organ Donation. Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164.500

**Other permitted and Required Uses and Disclosures:** Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

## Consent to Treatment

By signing below, I do hereby voluntarily consent to be treated with acupuncture by Inez Coppola, LAc. 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 this clinic's practitioners.

**Acupuncture/Moxibustion:** I understand that acupuncture is performed by the insertion of needles through the skin and moxibustion is performed by the application of heat to the skin. One or both is done 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 perception, 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, burning, scarring 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 that I may refuse this therapy.

**Gua Sha / Cupping:** I understand that gua sha is the rubbing of a flat edged tool along the skin to produce a local bruise to help in the flushing of pathogens. I understand that this bruising may last for a few days, and the skin may be sensitive to the touch. I understand that cupping is the draining of pathogens under the skin by way of a suction created by oxygen deprived glass cups. Cupping may leave marks or bruises that could last for a few days.

**Acupressure/Tui-Na Massage:** I understand that I may also be given acupressure/tui-na massage/shiatsu 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 the treatment if it is too uncomfortable.

I understand that I have the right to refuse any treatment offered to me and ask for treatment alternatives at any time.

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:** \_\_\_\_\_