Feeling Better Together

Balance & Wellness Through Health Care & Community

office@feelingbettertogether.com (703)626-4326

Client Information

Client Name (First, Middle, Last): _____

Guardian Name (If applicable): _____

Phone: (H) _____ (W) _____ (C) _____

Home Address: _____
(Street) (City) (State) (Zip Code)

Date of Birth: _____ **Age:** _____ **Sex:** _____

Email Address: _____

Emergency Contact Name/Number: _____

Name of Referring Person: _____

Name/Number of Primary Care Physician: _____

Services	Estimated Cost	Appointment Time
New Patient: Acupuncture/Craniosacral/Multi-Modality	$150	1.5 hours
Follow-Up: Acupuncture/Craniosacral/Multi-Modality	$90	1 hour
Telemedicine Wellness Coaching	$90	1 hour
New Patient: Allergy Evaluation (SAAT) with Needle Insertion (up to 6 needles)	$275	2 hours
Follow-Up: Allergy (SAAT) with Needle insertion	$135	1.5 hours
SAAT Needle Replacement: a follow-up visit	$120	1 hour

- Cancellation of appointments needs to be done at least 24 hours in advance in order to avoid a charge of a $50 no-show fee. There is a $25 fee for all administrative/consultative letters requested on behalf of the client.
- I understand that Feeling Better Together, LLC does not accept any form of health coverage and that I am fully responsible to pay the full charges of all services rendered at the time of the appointment. Upon request, we will provide a Universal Bill for the client to submit to his/her insurance company.
- A copy of this agreement may be used in place of the original.
- Please ask us any questions that you may have! Feeling Better Together is *By Appointment Only*. We will do our best to return phone calls or emails initiated by the client as soon as possible. If you do not hear from us within 3 business days of your initial contact, please reach out again. Neither our voicemail nor email is HIPPA compliant, so do not leave any health information in either location.

Signing below means that you have received this notice and understand the terms and fees listed above.

_____ _____
Signature of Client/Guardian Date

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Consent for Care Provided by Feeling Better Together

I hereby give Voluntary Consent: **Initial: _____**

- I hereby request and consent to be evaluated and treated through Complementary and Alternative Therapy approaches, including Auricular Medicine and/or therapy, Acupuncture, SAAT, Moxa, Craniosacral Therapy, Reiki, Nutritional Supplements (such as Sols), and Lifestyle Recommendations (including, but not limited to, exercise, nutrition, and breathing).
- The procedures involved have been explained to me, and I understand that I may be treated with needles (following the certified Clean Needle Technique), heat, and/or electrical stimulation.
- I understand the nature, purpose, and risks of the treatments/products/services offered by Feeling Better Together.
- I am free to discontinue services at any time.
- I knowingly, intelligently, and voluntarily accept the risk of the treatment/services/products provided with due care.

I agree to maintaining care under a primary care physician: **Initial: _____**

- I understand that I am expected to remain under the care of my conventional medical physician(s) for topics including, but not limited to, general care and care pertaining specifically to any & all illnesses, health concerns, and/or symptoms being experienced.
- I understand that it is best to combine the treatments recommended by Feeling Better Together with any physician recommended Conventional Medical Treatment.
- If I choose to abandon care under a traditional/primary care physician, in favor of the Complementary and Alternative Therapy approaches, then I consent that I do so AGAINST the advice of Feeling Better Together, and I take full responsibility for this decision.
- I will not delay or eliminate any treatment recommended by my Conventional Physicians.

I understand possible side effects/healing response: **Initial: _____**

- I understand that therapies/services offered by Feeling Better Together may result in certain side effects, including but not limited to local bruising, slight bleeding, fainting, and temporary pain or discomfort.
- I understand that any Complementary and Alternative Therapy (including any nutritional supplements) may cause temporary aggravation of symptoms existing prior to treatment.

I recognize that there is a lack of scientific data to support the efficacy of all approaches of care provided by Feeling Better Together. **Initial: _____**

- No member of Feeling Better Together has given me any guarantees or promises with respect to the outcome of the treatments/services/products recommended or provided by Feeling Better Together.

I agree to be an active participant in my own physical, mental, and spiritual health journey. **Initial: _____**

_____ _____
Client Signature Date

_____ _____
Signature of Parent/Guardian if client is a minor Date

_____ _____
Practitioner Signature Date

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Permission to Discuss

I, _____, give Feeling Better Together, LLC permission to discuss all of the following information (as indicated):

_____ All of the following

_____ Evaluation Results

_____ Billing Information

_____ Nutritional Supplement (Sol) Information

_____ Other (please specify): _____

With the following people:

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ _____

Signature of Client/Guardian Date

***Note: This form must be filled out in order to ensure the confidentiality of our client's records.

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Recommendation for Examination by a Physician

I, Charlotte Fandey, L.Ac., recommend to you,

_____,
Client Name (Print)

that you be examined by a physician regarding the condition for which you are seeking acupuncture treatment.

I understand this recommendation.

_____ _____
Client Signature Date

_____ _____
Acupuncturist Signature Date

Virginia law requires that I give this form to you if I do not have written evidence that you have received a diagnostic exam in the last six months from a licensed practitioner of medicine, osteopathy, chiropractic or podiatry regarding the condition for which you are seeking treatment. (Code of Virginia §54.1-2956.9, 18 VAC 85-110-10).

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Child/Guardian Consent for Care Permission Form

Date: _____

Client: _____

Guardian/Parent Name: _____

I give permission for my under 18-year-old child, _____, to be seen by Feeling Better Together, LLC, without my presence in the office. I will and do assume all responsibility for my child. I agree that he/she may be brought to Feeling Better Together by another adult or drive him/herself to receive treatment deemed necessary by Feeling Better Together, LLC.

_____

Parent/Guardian Signature

_____ _____

Feeling Better Together, LLC Practitioner Signature Date

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NOTICE OF PRIVACY PROCEDURES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- TREATMENT means providing, coordinating, or managing health care and related services by one or more health care providers.
- PAYMENT means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your medical plan for your medical services.
- HEALTH CARE OPERATIONS include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected information when we are required to do so by federal, state or local law. We may disclose your protected health information to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you for the request or to obtain an order protecting the information the party has requested. We will release your protected health information if requested by law enforcement officials for any circumstance required by law. We may release your protected health information to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

We may release protected health information to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your protected health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your protected health information if you are a member of US or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your protected health information to federal officials for intelligence and national security activities authorized by law. We may

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disclose protected health information to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your protected health information to correctional institutions or law enforcement officials if you are an Inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your protected health information for workers compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights with regards to your protected health information, which you can exercise by presenting a written request to our privacy office at the practice address listed above.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect and copy your protected health information
- The right to request an amendment to your protected health information
- The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the notice of privacy practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office. You have the right to file a formal, written complaint with us at the address above, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact

Privacy Official: Ralph Meoni (703)864-1831 Feeling Better Together	**For more information/to file a complaint RE: HIPAA,** The US Department of Health & Human Services Office of Civil Rights 200 Independence Avenue, SW Washington, DC 20201 (877)696-6775 (toll-free)

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RECEIPT OF NOTICE OF PRIVACY PROCEDURES

I, _____, have been given the opportunity to review a
Patient Name

copy of the *Notice of Privacy Procedures* for the office of Feeling Better Together.

_____ _____
Signature of Patient/Guardian Date

_____ _____
Witness Date