Kerri Westhauser, L.Ac.

1330 New Hampshire Ave NW B4
Washington, DC 20036
(703) 231-3930

803 W. Broad Street # 750
Falls Church, VA 22046
(703) 231 3930

New Patient Registration Form Date_____

Name_____Date of Birth_____ Age_____
Address_____
City_____ State_____ Zip _____
Home Phone _____Cell Phone _____ Work Phone _____
E-mail Address _____
Sex_____ Marital Status _____
Occupation _____Employed by _____
Emergency Contact _____Relationship _____ Phone _____
Whom may we thank for referring you? _____

Policy Statement

Payment is due at the time service is rendered, unless alternative arrangements are made prior to treatment.
A receipt will be provided for insurance reimbursement submission by the patient.
Time is reserved for your appointment. Please give a 24 hours notice if an appointment can not be kept, otherwise you will be charged for missed appointments.
I understand and agree to the above policy statement.

X_____ _____
Signature of Patient (Parent/Guardian) Date of signature

Consent Form

I understand that acupuncture is performed by the insertion of needles through the skin with or without the use of electrical stimulation, with or without the application of heat (moxibustion, heat lamp), and/or other techniques (i.e. cupping, manipulation) at acupuncture points.

I understand that certain adverse effects may result from treatment. These could include, but are not limited to, slight bleeding and bruising or soreness at the insertion site. Fainting or dizziness may occur in a patient who is highly anxious, extremely fatigued, or hungry.

I understand that there is no guarantee concerning the effect of the treatment provided to me and that I am free to discontinue treatment at any time.

I understand that acupuncture is not a substitute for Western Medical treatment and that if I am under the care of a Physician for a particular ailment or condition, I should continue my care until advised differently by my Physician.

I do hereby consent to be treated with acupuncture.

X_____ _____
Signature of Patient (Parent/Guardian) Date

Assignment and Release:

I, the undersigned, certify that I have insurance coverage and assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature on all insurance submissions.

_____
(responsible party signature) (date)

KERRI WESTHAUSER, L. Ac.

(703) 231-3930

PRIVACY POLICY

This notice describes how Kerri Westhauser, L. Ac. protects your health information and what rights you have regarding it. I am are obligated by law to give you notice of our privacy practices. Please review it carefully.

Right to Notice

As a patient, you have the right to adequate notice of the uses and disclosures of your protected health infatuation. Under the Health Insurance Portability and Accessibility Act (HIPPA), Kerri Westhauser, L. Ac. can use your protected health information for treatment, payment, and health care operations.

a) Treatment - I may use or disclose your health information to a physician or other health care provider providing treatment to you.

b) Payment - I may use and disclose your health information to obtain payment for services that I provide to you.

c) Health care operations - I may use and disclose your health information in connection with my healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of health care professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization

Most uses and disclosures that do not fall under treatment, payment, health care operations will require your written authorization. Upon signing, you may revoke your authorization (in writing) through my practice at any time.

Emergency Situations

In the event of your incapacity or an emergency situation, I will disclose health information to a family member, or other person responsible for your care, using our professional judgment. I will only disclose health care information that is directly relevant to the person's involvement in your health care.

Marketing

I will not use your health information for marketing communications without your written authorization.

Required by Law

I may also use or disclose your health information when I are required to do so by law.

Abuse or Neglect

I may disclose your health information to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. I may disclose your health information to the extent necessary to avert a serious threat to your or other people's health and safety.

National Security

I may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. I may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. I may disclose health information of inmates or patients to the appropriate authorities under certain circumstances.

Please complete *overleaf.* Thank *you.*

Appointment Reminders

I may use or disclose your health information to provide you with appointment reminders via phone, e-mail or letter.

Your Rights as a Patient

-You have the right to restrict the disclosure of your protected health information (in writing). The request for restriction may be denied if the information is required for treatment, payment, or health care operations.

-You have the right to receive confidential communications regarding your protected health care information.

-You have the right to inspect and copy your protected health information (PHI). Requests for copies of PHI must be made in writing to our office and will be available for review within 30 days of the date of the request.

-You have the right to amend/update your protected health information. To provide the best health care possible, it is always recommended that you keep me up-to-date on ALL of your health information/conditions.

-You have the right to receive an account of disclosures of your protected health information. My office will provide within 30 days of a written request.

-You have the right to a paper copy of this notice of privacy practices.

Legal Requirements

Kerri Westhauser, L. Ac. is required by law to maintain the privacy of your protected health information. I am are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. The policies in any new notice will not be in effect until they are posted within our office.

Complaints

It is always my utmost goal to treat my patients with care and respect. If, hoIver, you have complaints regarding the way that your protected health information is handled, you may submit a complaint to my office. I hope that you always let me know what I may do to improve your patient care.

Contact Information .

For further information about my privacy policies, please contact Kerri Westhauser, L. Ac.
(703) 231-3930.

Please acknowledge your understanding and acceptance of these practices and policies by signing below.

Client Name: _____

Signature: _____

Date: _____