CONSENT

Voluntary

I hereby voluntarily consent to acupuncture treatment, cupping and herbal formulas (as warranted) with Balance and Flow Acupuncture and Coaching, LLC. The procedures involved in acupuncture and cupping treatment have been explained to me. I understand that I may be treated with the insertion of needles, cupping, gua sha, and/or with the application of heat to the skin. I also understand that Balance and Flow Acupuncture and Coaching, LLC might also make recommendations related to diet, exercise, herbs and lifestyle consistent with Chinese Medical therapy, or might suggest additional therapies to support treatment.

Possible side effects/healing response

I understand that acupuncture may result in side effects, including local bruising, slight bleeding, fainting, temporary pain or discomfort and temporary aggravation of symptoms existing prior to treatment. Herbs provided through Balance and Flow Acupuncture and Coaching, LLC are generally recognized as safe and sourced from professional companies with the highest quality controls including independent, third party evaluations when applicable.

No guarantees

I understand that each person is unique in their response to treatment, and each person has ultimate responsibility for his or her healthcare. I acknowledge that I have not received any guarantees or promises as to the results or success that will be obtained from the services provided.

Infections Disease Prevention

I understand that infectious disease is carried through the air, through physical contact, and through body fluids. I understand that universally prescribed precautions to prevent the spread of infection are followed.

Client responsibilities

I understand that it is my responsibility to inform Balance and Flow Acupuncture and Coaching, LLC of all aspects of my health and that, as service progresses, to inform her of changes that occur. I will inform Balance and Flow Acupuncture and Coaching, LLC if I am pregnant, or suspect pregnancy at any time. If I experience any pain, discomfort, or possible adverse side effects, it is my responsibility to notify Balance and Flow Acupuncture and Coaching, LLC. Please see office guidelines for email, text and phone contact.

Medical treatment

I understand that acupuncture, cupping and herbs are not a substitute for medical care by a licensed physician, nor will Balance and Flow Acupuncture and Coaching, LLC suggest that I discontinue medical treatment. I understand that if I am currently under the care of a licensed physician, it is my responsibility to consult with my physician before altering any medications or medical treatment. I understand that if there is a worsening of my ailment or condition, or if a new ailment or condition arises, that I should consult a licensed physician.

Confidentiality

I understand that Balance and Flow Acupuncture and Coaching, LLC respects my privacy and will only release information required to further my treatment, assist me in obtaining payment, managing her own internal operations, or as specifically authorized by me.

Fees and Cancellation

I have been informed of the fees and understand that payment is due *at the time of service*. I understand that cancellations **without 24 hours notice will be charged** a $50 fee for the first time. A full appointment fee of $100 will be assessed thereafter. Future treatments will not be scheduled until all outstanding fees are paid. ***Three*** **missed appointments/late cancellations** require conversation for continued treatment. Our office reserves the right to request upfront payment for herbs and appointments. I understand that Balance and Flow Acupuncture and Coaching, LLC welcomes my questions about treatment and will provide the answers to my questions. I have read this form carefully and have felt free to ask any questions regarding this process, and it has been satisfactorily explained to me.

Signature of patient or guardian:_____ **Today's Date:**_____

Printed name patient or guardian:_____ **Today's Date:**_____

Notice of Privacy Practices

The Health Insurance Portability and Accountability Act (HIPAA) requires health care professionals to give their clients a Notice of Privacy Practices and clients to sign an acknowledgement that they received the Notice. This is the Notice of Privacy Practices for this office. Please let me know if you have any questions or requests.

Confidentiality of Client Records
Information about your care is confidential and is protected in the following ways:

- First, your file is securely stored in a locked file cabinet when it is not in use.
- Second, information about you is not divulged unless you have signed a consent for the release of information. Any such release would contain the name of the person who would be receiving your health care information.
- Third, if you have filed an insurance claim and the insurance company contacts me for additional information, I will give the insurance company the "minimum necessary to comply with the insurance company's request."
- Fourth, I use a HIPAA compliant virtual platform for telehealth appointments.

Communications with You
This form gives me permission to contact you at the phone number(s), address(es), and/or email addresses you have given me, unless you specifically request otherwise.

Notice of Privacy Practices
I hereby acknowledge receipt of the Notice of Privacy Practices for the acupuncture and coaching practice of Balance and Flow Acupuncture and Coaching, LLC.

Signature of patient or guardian:_____ **Today's Date:**_____

Printed name patient or guardian:_____ **Today's Date:**_____

Email: _____

Address: _____

_____

Phone # (where it is ok to leave a message):_____

May I contact you by text? ___yes ___no

- This is for appointment reminders and quick communications. You can opt out at any time.

May I contact you by email? ___yes ___no

- You can opt out at any time.

Would you like to receive email updates, news and health resources? ___yes ___no
*We do not sell or share your contact information. You can opt out at any time.

For your security, please refrain from sharing your confidential health information using text and email.
*Please see my email/text/phone guidelines for treatment communications.

Balance and Flow Acupuncture and Coaching, LLC

CLIENT INTAKE FORM

Full Name:_____**preferred pronoun:**_____ **DOB:** _____

Address:_____**City:**_____**State:**_____**Zip:**__

Phone: _____**Email:** _____

_____

Emergency Contact: _____**Phone:** _____

Relationship: _____

Physician: _____**Phone:** _____

In the event of an emergency, may I contact your physician or emergency contact? ___ yes ___ no

How did you learn about my practice:_____

Rx/Supplement Taken	**Dose**	**Condition**	**Rx/Supplement taken**	**Dose**	**Condition**

Check all conditions current and previous that apply:

__ High/low blood pressure (circle which)	__ autoimmune: _____	__ Blood clots/circulatory	__ Headaches
__ Cancer	__ diabetes	__ skin conditions : _____	__ accidents/trauma
__ Seizures	__ heart conditions: _____	__ Respiratory : _____	__ digestive: _____
__ kidney disease	___ liver disease	__ joint/muscle pain : _____	__ reproductive: _____

__ allergies __ shell fish ___ tree nuts __ dairy ___ gluten ___ flowers/plants _____

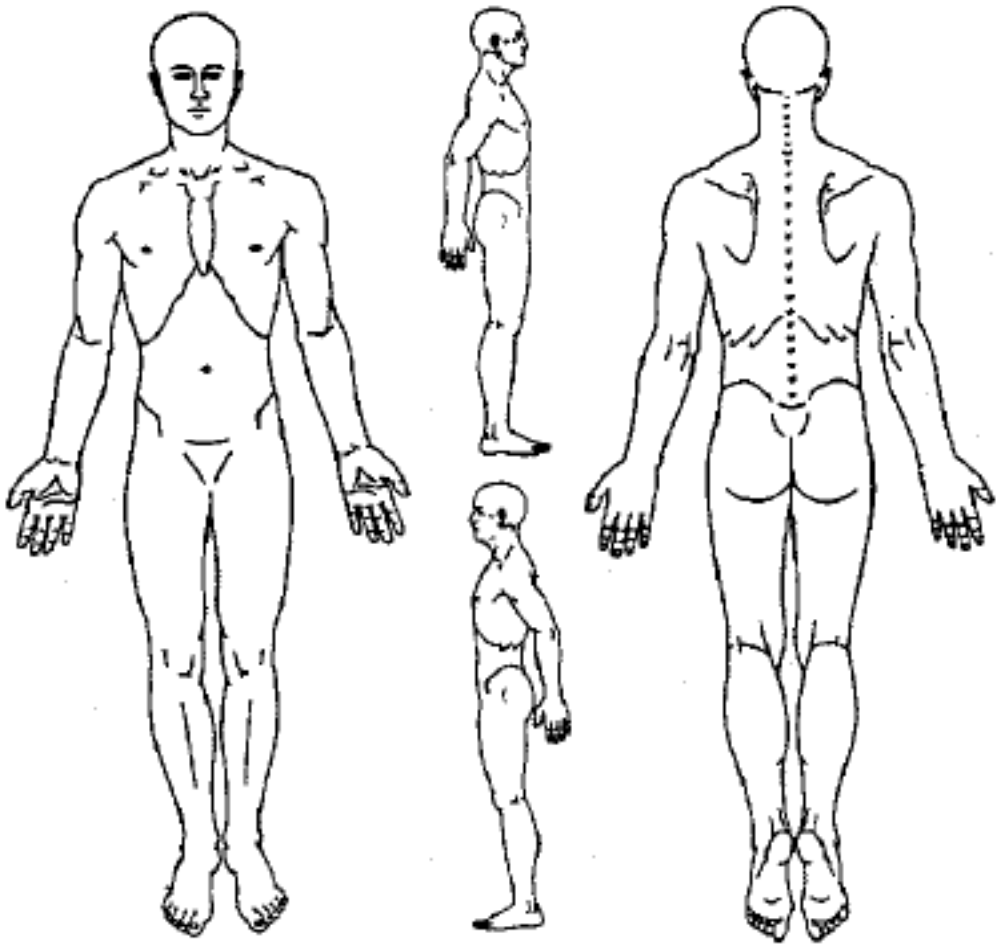
Other: _____

Signature:_____ **date:**_____

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^ ^	X X X X	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^ ^	X X X X	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^ ^	X X X X	⊗ ⊗ ⊗ ⊗



Please use the space below to describe your condition further if needed:

_____

_____

_____

Guidelines for email/text/phone contact:
Please keep this for your reference

Feel free to email/text me if you have a very specific question about treatment or an herb I've recommended – for example, you need to clarify something about dosage or have not received your order, or you need to confirm your appointment.

While I welcome your questions about treatment, my office policies, and all things acupuncture, please understand that I cannot answer in-depth treatment questions or provide treatment advice over email, text or phone – these will need to be discussed at your in person appointments.

Feel free to share hard copies of labs or other health information that you feel is relevant to your care, that you would like to discuss. **Please do not send labs or health reports via email or text or social media or other unsecure sites**. These can be discussed during your in person appointments.

For anything urgent, including last minute scheduling changes or additions, please don't rely on email. Text or phone is best for questions that need immediate responses. And of course, if you experience anything concerning or medically urgent, please seek immediate medical attention.

Good Faith Estimate – please retain for your reference

Pursuant to the No Surprises Act (HR133, Title 45 Section 149.610), this form is used to provide a current or prospective client with a "Good Faith Estimate" (GFE) of expected charges for intake.

PROVIDER INFORMATION FOR: Balance and Flow Acupuncture and Coaching, LLC (Balance and Flow Wellness)

Provider: Balance and Flow Acupuncture and Coaching, LLC (Balance and Flow Wellness)
Facility Type: Health Care
Street address: 2837 N Front St., Suite 101, Harrisburg PA 17110
Contact person: Rebecca Thoroughgood (Owner)
Phone: 717-303-8579
Email: findbalanceandflow@gmail.com

Organization's National Provider Identifier (NPI): **1609994599**
Balance and Flow Acupuncture and Coaching, LLC Taxpayer Identification Number (EIN): **39-3010201**

BRIEF EXPLANATION OF GOOD FAITH ESTIMATES

You are entitled to receive this "Good Faith Estimate" of what the charges could be for acupuncture services provided to you. While it is not possible for an acupuncturist to know, in advance, how many sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of acupuncture sessions you attend, your individual circumstances, and the type and amount of services that are provided to you. This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services that may be recommended during treatment to you that are not identified here.

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of acupuncture visits. The number of visits and any supplements or herbs that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your practitioner. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

In addition to an intake, most new clients will attend one acupuncture visit per week for about 4-6 weeks, however the frequency of visits that are appropriate in your case may be more or less than once per week, depending upon your needs. If herbs are recommended in addition to treatment, the costs will be provided. You and Balance and Flow Acupuncture and Coaching, LLC will determine a treatment schedule for continued or follow-up care based on your needs.

SERVICES & FEES AT Balance and Flow Acupuncture and Coaching, LLC Acupuncture:

$60 Intake-new patient- 20-30 minutes (99203)

$100 In person acupuncture appointment – 60 minutes (97810, 97811)

$60 abbreviated in-office acupuncture visit (20-30 minutes) (97810)

$60 *abbreviated follow up visit – established client (herbs, progress, evaluation and management- 15 minutes*) (99213)

$60 Cupping -30 minutes (97039)

$65 Cupping mobilization-30-45 minutes (97139)

$55 Gua Sha-30 minutes (97139)

$55 Moxabustion-30 minutes (97139)

$100 herbal consult (45-60 minutes) (99203)

OTHER RATES

$50 Outside Clinical Paperwork / Phone Consults (15m increments)

$50 first time missed appointment, $100 thereafter for Late Cancellation/No Show without 24-hour notice

$.50/p Paper Copy of Client Records for Personal Use

These are the common services provided by your acupuncturist. If services other than these are recommended for you to receive at Balance and Flow Acupuncture and Coaching, LLC Acupuncture, a separate Good Faith Estimate will be provided.

You have a right to dispute a bill if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means $400 or more beyond the estimated charges). Initiating the dispute process will not adversely affect the quality of services rendered to you. You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you, you will have to pay the higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call HHS at (800) 368-1019. Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate.