# Acupuncture & Chinese Medicine
## Legal Consent

Form to be completed by Patient, notifying the Acupuncturist of whether he/she has been evaluated by a physician and other information. [Pursuant to the requirement of section 183.7(e) of this title (relating to the denial of Licensee; Discipline of Licensee) and section 6.11, subsections(b) through (d), V.A.C.S., article 4495b, governing the practice of acupuncture.]

I (patient's name) _____, am notifying the acupuncturist (practitioner's name) _____ of the following:

☐ Yes ☐ No

I have been evaluated by a physician or dentist for the following condition being treated within twelve months before the acupuncture was performed. I recognize that I should be evaluated by a physician for the condition being treated by the acupuncturist.

**OR**:

☐ Yes ☐ No

I have received a referral from my chiropractor within the last 30 days for acupuncture. After being referred by a chiropractor, if after 120 days or 30 treatments, whichever comes frst, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility to follow this advice.

Signature: _____ Date: _____

# PRIVACY

I acknowledge that I have been provided access to the Body Collective “Notice of Privacy Practices”. I understand that I have the right to review the “Notice of Privacy Practices” prior to signing this document.

I understand that Body Collective staff members may need to contact me with information related to my treatments. If this contact is to be made by phone, and I am not at home, a message will be left on my answering machine or with anyone who answers the phone. I understand that appointment confirmation and reminders will be sent via email. I understand that I will be required to send Intake and Health History information direction to my practitioner via email.

| | |
|---|---|
| _____ | _____ |
| Patient Name (print) | Date |
| _____ | _____ |
| Patient Signature | Body Collective Privacy Rep/Date |

# DISCLOSURE OF HEALTH INFORMATION

**(Optional)**

I, _____, hereby authorize Body Collective the use or disclosure of my individually identifiable health information to the party(s) described below. I understand this authorization is voluntary. I understand if the party(s) authorized to receive my information is/are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/Organizations authorized to receive information: (please print)

_____

_____

_____

Patient’s Signature: _____ Date: _____