McBride Healing, LLC

FINANCIAL POLICY & APPOINTMENT REMINDER FORM

MCBRIDE HEALING, LLC MAKES EVERY ATTEMPT TO MAKE ALTERNATIVE HEALTH CARE, SUCH AS ACUPUNCTURE AND CHINESE MEDICINE, AVAILABLE TO AS MANY PEOPLE AS POSSIBLE, AT THE MOST AFFORDABLE RATES.

IN RESPECT FOR OUR INTENTION TO OFFER HIGH QUALITY HEALTH CARE AT AFFORDABLE PRICES, WE ASK FOR 24 HOURS NOTICE IN ADVANCE OF AN APPOINTMENT IF IT IS NECESSARY TO CANCEL OR RESCHEDULE AN APPOINTMENT.

ALL APPOINTMENTS THAT ARE RESCEDULED OR CANCELLED WITH LESS THAN **24** HOUR ADVANCE NOTICE, AND APPOINTMENTS MISSED WITHOUT NOTICE, WILL BE CHARGED **$30** FOR THAT APPOINTMENT. IF APPOINTMENTS HAVE BEEN PURCHASED IN A PACKAGE, THE MISSED, CANCELLED OR RESCHEDULED APPOINTMET WILL BE DEDUCTED FROM THE NUMBER OF REMAINING APPOINTMENTS IN THAT PACKAGE.

I UNDERSTAND THAT MCBRIDE HEALING, LLC MAY NEED TO CONTACT ME WITH APPOINTMENT REMINDERS OR 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 VOICEMAIL, ANSWERING MACHINE, OR WITH ANYONE WHO ANSWERS THE PHONE.

THANK YOU FOR YOUR UNDERSTANDING,

MCBRIDE HEALING LLC

_____	_____
Patient's Name (please print)	Patient's Signature Date
_____	_____
Print Name of Patient's Representative (if applicable)	Relationship or Authority of Patient's Representative
_____	_____
Signature of Patient's Representative (if applicable)	Date Signed

McBride Healing, LLC

HIPPA Consent for Purposes of Treatment, Payment and Health Care Operation

I consent to the use or disclosure of my identifiable health information by McBride Healing, LLC for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me at McBride Healing, LLC may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. McBride Healing, LLC is not required to agree to the restrictions that I may request. However, if McBride Healing, LLC agrees to a restriction that I request, the restriction is binding upon McBride Healing, LLC.

I have the right to revoke this consent, in writing, at any time except to the extent that McBride Healing, LLC has taken action in reliance on this consent.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review McBride Healing, LLC's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations of review McBride Healing, LLC. The Notice of Privacy Practices is also provided at the front desk of McBride Healing, LLC. This Notice of Privacy Practices also describes my rights and the duties of my practitioners and McBride Healing, LLC with respect to my identifiable health information.

McBride Healing, LLC reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by accessing the website or requesting the most current notice during any office visit.

Patient's Name (please print)	Patient's Signature Date
Print Name of Patient's Representative (if applicable)	Signature of Patient's Representative (if applicable)
Relationship or Authority of Patient's Representative	Date Signed

McBride Healing, LLC

INFORMED CONSENT TO ORIENTAL MEDICAL HEALTH CARE

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by the licensed acupuncturists of McBride Healing, LLC who now or in the future treats me while working at this clinic or any other associated clinic: acupuncture and other oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of the body, observation, range of motion, muscle and orthopedic testing; modes of manual or physical therapy such as bodywork, manipulation of joints and /or viscera, heat and/or cold therapy, electrical and/or magnetic stimulation, cupping and/or moxibustion; the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendations; exercise advice, and healthy lifestyle counseling.

I understand I have an opportunity to discuss with my licensed acupuncturist and/ or with other clinic personnel the nature and purpose of acupuncture and oriental medical procedures. Although I am aware that acupuncture and the other procedures used in oriental medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of allopathic medicine, in the practice of oriental medicine there are some risks to treatment. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: slight bleeding, bruising, pain or other strong sensation at the location of where a needle is inserted or radiating from that location, nerve pain, minor burns, aggravation of current symptoms, appearance of new symptoms, general aches, and fainting. Other uncommon but possible risks include pneumothorax (punctured lung), puncture of other organs, sprains, strains, dislocation, fractures, disc injuries and strokes. I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioner to exercise such judgment, during the course of my treatment, as the practitioner feels at the time, based on the facts then known, to be in my best interest.

I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask questions about the content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment at McBride Healing, LLCp.

Patient's Name (please print)	Patient's Signature Date
Print Name of Patient's Representative (if applicable)	Relationship or Authority of Patient's Representative
Signature of Patient's Representative (if applicable)	Date Signed