TEXT AND EMAIL POLICY AND CONSENT FORM

LAURI ELIZABETH, LLC
630 SE Powell Blvd.
Portland, OR 97202

Before sending email/text communications to Lauri Elizabeth, please read and agree to the following information regarding the risks and conditions of email/text use:

RISKS ASSOCIATED WITH USING EMAIL/TEXT

Lauri Elizabeth offers patients the opportunity to communicate by email/text. However, transmitting patient information by email/text has a number of risks that should be considered. These include, and are not limited to, the following risks:

- Email/text can be circulated, forwarded, and stored in paper and electronic formats, and can be broadcast to unintended recipients.
- Email/text senders can easily misaddress an email/text and send confidential information to an unintended recipient.
- Backup copies of email/text may exist even after the sender and/or recipient(s) have deleted their copies.
- Employers and on-line services have a right to archive and inspect emails/texts sent through their company systems.
- Email/text can be intercepted, altered, forwarded, or used without authorization or detection.
- Email/text can be used as evidence in court.
- Email/text messaging may not be secure, and it is possible that a third party may breach the confidentiality of these communications.

CONDITIONS FOR THE USE OF EMAIL/TEXT

Lauri Elizabeth cannot guarantee but will use reasonable means to maintain security and confidentiality of email/text information sent and received, and will not be liable for improper disclosure of confidential information that is not caused by Lauri Elizabeth's intentional misconduct. You must acknowledge and consent to the following conditions:

- **For medical emergencies, call 911**, do not use email/text. For urgent or time-sensitive matters, during business hours, call Lauri Elizabeth at (503)816-1443.
- Emails/texts should not be time-sensitive. While Lauri Elizabeth tries to respond to email/text messages within 24 hours, if you have not heard back from her within three days, call (503)816-1443 to follow up and see if she received your message.
- Emails/texts may be filed electronically in your medical record, and thus may be available to other practitioners involved in your care.
- Lauri Elizabeth may forward emails/texts internally to the practice's staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling. Lauri Elizabeth will not forward emails/texts to independent third parties without your prior written consent, except as authorized or required by law.
- You should not use email/text communication regarding sensitive medical information such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability,

or substance abuse. You are responsible for informing Lauri Elizabeth of any types of information that you desire not to be sent by email/text, in addition to those called out above.

- The individual is responsible for protecting his/her password or other means of access to email/text. Lauri Elizabeth is not liable for breaches of confidentiality caused by the patient or any third party.
- Lauri Elizabeth shall not engage in email/text communication that is unlawfully practicing medicine across state lines.
- It is the individual's responsibility to follow up with Lauri Elizabeth, if warranted.

COMMUNICATION BY email/TEXT

To communicate by email/text, patients shall:

- Limit or avoid the use of his/her employer's computer.
- Inform Lauri Elizabeth of changes in his/her email/text address.
- Put the patient's name in the body of the email/text.
- Review the email/text to make sure it is clear and that all relevant information is provided before sending to Lauri Elizabeth.
- Take precautions to preserve the confidentiality of email/text, such as using screen savers and safeguarding his/her computer password.
- Withdraw consent only by written communication to Lauri Elizabeth.

ACKNOWLEDGEMENT & AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the use of email and text messaging as a form of communication between Lauri Elizabeth and me, and consent to the conditions and instructions outlined, as well as any other instructions that Lauri Elizabeth may impose to communicate with me by email or text message.

_____ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number. The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is ___________________________.

_____ (Patient initials) I consent to receive emails, to receive communications as stated above. The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is____.

______________________________	______________________________
Patient printed name	Patient date of birth
______________________________	______________________________
Patient signature	Today's date
______________________________	______________________________
Guardian printed name	Today's date
______________________________	
Guardian signature	

FINANCIAL POLICY AND ASSIGNMENT OF BENEFITS

LAURI ELIZABETH, LLC
630 SE Powell Blvd.
Portland, OR 97202

Insurance Billing: Lauri Elizabeth, LLC may bill your health insurance as a courtesy to you, provided that she is contracted with the insurance company. This does not guarantee payment by the health insurance company and you are liable for any amount not covered by the health insurance company, barring a prohibition against such practices by the contract between Lauri Elizabeth, LLC and the insurance company. Benefits verification is an estimation of benefits and not a guarantee of payment. Copays and coinsurance amounts are due at the time of service and can be paid via cash, check, or credit card (Visa, MasterCard, Discover, American Express).

Time of Service Payment: If Lauri Elizabeth, LLC is not contracted with your insurance company (out of network), or if you choose not to ask Lauri Elizabeth, LLC to bill the insurance company for any reason, payment is required at the time of service in the form of cash, check, or credit card (Visa, MasterCard, Discover, American Express). You may use your receipts to request reimbursement by insurance or a Health Savings Account (HSA). For more information about which expenses are allowable under your HSA or insurance, please contact them directly.

Changes in insurance: Please notify Lauri Elizabeth, LLC immediately of any changes in your insurance or coverage.

Fees: Fees will be collected in full prior to your next appointment and are generally not covered by insurance companies.

- Late cancellations (less than 24 hours' notice) - $25
- Missed appointments - $25
- Returned check fee - $25
- A finance charge of 1.5% per month may be added to any overdue accounts (those not paid within 30 days).

Late arrivals: Patients arriving later than 15 minutes may have their appointment canceled with the option of rescheduling for a later day/time. In such cases, the late cancellation fee will apply.

Repeated late arrivals, late cancellations, missed appointments or returned checks may result in the patient being referred to another practitioner.

For patients using the online scheduling service, the late cancellation and missed appointment fees may be automatically charged to a credit card set up with the online scheduling service.

Exceptions to this financial policy occur where the contract between Lauri Elizabeth, LLC and the insurance company prohibits such fees.

I acknowledge that I have read and agree to the above financial policies. I request that authorized insurance payments be made on my behalf to Lauri Elizabeth, LLC for any services furnished to me by the provider. I authorize the release of any medical information requested about me that is necessary to determine benefits, payable or otherwise, for related services.

I understand that health insurance carriers occasionally send payments to the patient instead of the provider. Should this happen, I agree to sign over the payment to Lauri Elizabeth, LLC within 10 business days of receiving the payment.

Patient printed name ____________________ Patient date of birth ____________________

Patient signature ____________________ Today's date ____________________

Please fill out your health insurance plan information below if you would like Lauri Elizabeth, LLC to bill your insurance company. If you are seeking care for a Motor Vehicle Accident or Worker's Compensation claim, please fill out our separate form for such claims. If you have secondary insurance, please provide the same information on a separate sheet.

Name of Insured ____________________ Effective since (date) ____________________

Insurance Company ____________________ Insurance Phone Number ____________________

Insurance ID Number ____________________ Group Number ____________________

Relationship to insured ____________ Copay or coinsurance? ____________ Copay amount ____________

ACUPUNCTURE INFORMED CONSENT TO TREAT

LAURI ELIZABETH, LLC
630 SE Powell Blvd.
Portland, OR 97202

Please read this document carefully and sign on page 2.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, gua sha, electrical stimulation, bodywork, use of non-insertive tools, herbal medicine, and nutritional counseling. I understand that there are many alternatives to treatment with acupuncture and related modalities, including treatment by a primary care provider.

Acupuncture: I have been informed that acupuncture is a generally safe method of treatment where needles are inserted into the skin. It may have some side effects, including pain, bruising, numbness or tingling near the needling sites that may last a few days, dizziness, nausea, and fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile, disposable needles and maintains a clean and safe environment.

Moxibustion and other heat therapies: Moxibustion is the burning of an herb (usually mugwort) on or near the skin. Burns, marks, and/or scarring are a potential risk of moxibustion, or when treatment involves the use of heat lamps or other heat therapies. Respiratory aggravation is a possible side-effect of moxibustion.

Cupping and gua sha: Cupping is the application of glass, plastic or silicone cups on the skin, held by suction. Gua sha is scraping the skin and underlying tissues with a hard tool. Bruising is a common side-effect of cupping and gua sha. Scarring or other marks are uncommon potential risks of cupping and gua sha.

Herbal therapy: I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify my practitioner of any unanticipated or unpleasant effects associated with the consumption of the herbs. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that may be recommended are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses or when improperly prepared. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I

understand that if I take herbs and they cause me problems, I will stop taking them immediately and notify my practitioner. I will notify my practitioner if I am or become pregnant.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

Primary Care Provider: I understand that, in Oregon, acupuncturists are not considered primary care providers. I understand that I should establish care with a primary care provider before starting treatment with Lauri Elizabeth. I will inform Lauri Elizabeth, if I do not have a primary care provider. Patients are encouraged to keep in contact with their primary care provider during the course of treatment.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

Practitioner's name: Lauri Elizabeth, LAc

____________________	____________________	__________
Patient printed name	Signature	Date

PERSONAL HEALTH HISTORY – NEW PATIENT FORM

LAURI ELIZABETH, LLC
630 SE Powell Blvd.
Portland, OR 97202

All answers are confidential. Please use separate page if there's not enough space for your information.

Demographic Information

Full Name: Preferred Name:

Sex: Date of birth: Age:

Preferred phone: May I leave a voicemail at this number?

Address:

City/State/Zip:

Primary Care Provider's Name: PCP's phone:

Health Information

Do you have any current diagnoses? Please be as specific as you can. Include chronic conditions that were diagnosed a long time ago.

Diagnosis	Date diagnosed (year is ok):	Currently being treated?

Health Information (continued)

Major event/hospitalization	Year	Operation/illness

Any relevant family health history you would like me to know about?

Social History

Smoking status:

Dietary Restrictions:

Exercise:

Allergies

Allergy (drug/food/environmental)	Onset (childhood/adult)	Severity	Reaction

Current Medications & Supplements

Name of medication or supplement	Dose/ frequency	Reason for using	Start date (year ok for long-term meds)

Unelaborated List of Health Concerns

Please list your health concerns in order of importance, including what brings you in today for treatment:

ACKNOWLEDGMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, ____, hereby acknowledge that LAURI ELIZABETH, LLC has provided me with a copy of its Notice of Privacy Practices that describes:

- How protected health information about me may be used to plan and direct my treatment including treatment coordination with other practitioners
- How protected health information about me may be used to bill for services
- My privacy rights with regard to my protected health information
- This office's obligations concerning the use and disclosure of my protected health information
- How I can access this information

In addition, I understand that Lauri Elizabeth uses email and fax to submit insurance claims, complete benefit checks, inquire about claims, and other communications regarding insurance coverage. If I am not comfortable with this, I will notify Lauri Elizabeth at the address below and ask her to use alternate methods of communication.

I understand that if I have questions or complaints I may contact:

LAURI ELIZABETH, LLC
630 SE Powell Blvd.; Portland, OR 97202

I also understand that I am entitled to receive updates upon request if LAURI ELIZABETH, LLC amends or changes its Notice of Privacy Practices in a material way.

____________________________	____________________________	__________
Printed name	Signature	Date
____________________________	____________________________	__________
Guardian printed name	Signature	Date

THIS SECTION IS TO BE COMPLETED BY LAURI ELIZABETH, LLC IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:
[ ] Patient declined to sign this Written Acknowledgment.
[ ] Other (specify):

____________________________	____________________________	__________
Employee printed name	Signature	Date

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.