HEARTWOOD
HEALING COLLECTIVE

THERAPEUTIC AGREEMENT

HEALTH INFORMATION

I consent to the use or disclosure of my identifiable health information by Heartwood Healing Collective, 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 by Heartwood Healing Collective, LLC may be conditioned upon my consent as evidenced by my signature on this document. 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. Heartwood Healing Collective, LLC is not required to agree to the restrictions that I may request. However, if Heartwood Healing Collective, LLC agrees to a restriction that I request, the restriction is binding upon Heartwood Healing Collective, LLC.

I have the right to revoke this consent, in writing, at any time except to the extent that Heartwood Healing Collective, 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 or another health care provider. 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.

CONFIDENTIALITY

Information shared is kept confidential unless released in writing by you, subject to these limits:

1. There is convincing evidence that you are in immediate danger to yourself or others. Legal action may be taken for your own protection and that of others.
2. You are involved in a medical emergency.
3. Suspected child or elder abuse, including physical or sexual abuse or neglect must be reported by Heartwood Healing Collective to the necessary state and local agencies.
4. Members or affiliated staff of Heartwood Healing Collective are subpoenaed by a court of law to release your information.

COORDINATION OF CARE

If you would like the coordination of your care with that of your physician or other alternative health care provider you must sign a medical records release form for each specific individual therapist.

ARRIVAL TIME

Please arrive no earlier than five to 10 minutes prior to your scheduled appointment. If you are going to be late, please contact us in a timely manner via phone. Your lateness may shorten the time of your session. You are expected to pay for your contracted time despite any possible lateness on your part.

CONFIRMATIONS, CANCELLATIONS AND NO SHOWS

You will receive a confirmation of your session at least 24 hours prior. Please allow your therapist at least 24-hours notice of your scheduled appointment time if you need to cancel your session. **100% of the session fee is expected if the cancellation occurs with less than 24 hours of notice and we are unable to fill your slot**. If you no-show for an appointment full payment is required and you will be asked to pre-pay future sessions. Exceptions may be made for sudden illness, accidents or emergencies. If we need to cancel your session, we will make all efforts to provide you with at least 24-hour notice.

ILLNESS

If you are experiencing symptoms of a cold or flu, have had a recent injury or are under a physician's care for serious or communicable health issues some services at Heartwood may not be appropriate for you. You may

need to provide the proper paperwork from your health care provider and/or reschedule your session. Additionally, in some instances massage may be contraindicated. This may be discerned at our session. In the event that we are unable to work with you due to contraindication you are still responsible for paying for your scheduled session. If you are unsure if a given service is contraindicated for you during a specific illness please contact your therapist ahead of your scheduled appointment to discuss.

FEES

Payment is due at the time of session and is based upon our agreed rate and session length. Cash or check are accepted. We do not provide direct billing for insurance. If your financial situation changes in any way, please let us know so we can discuss the possibility of making adjustments. A $35 fee will be taken on all returned checks.

COMMUNICATIONS

Please silence your telephone and pager when you arrive. You are entering a therapeutic and sacred space designed to create an atmosphere of relaxation and healing. Occasionally we will offer a newsletter relating to bodywork, yoga, meditation and health. Also, we may provide post-session follow up communications. These are to monitor how you integrate our work together and offer a continuity of care. Please circle your preferences regarding these communications:

Newsletter YES / NO

Session follow ups YES / NO email phone call (ok to leave a msg? YES / NO) text

CLIENT-THERAPIST RIGHTS

Either of us has the right to end the session for any reason at any time. Sexual behavior or innuendo by client or therapist is unacceptable and grounds for ending a session. In the event the session is terminated early you are responsible to pay your full session fee.

I understand that there is a 24-hour cancellation policy. I understand that I will be charged the full cost of the treatment if I have a missed appointment or a late cancellation. Please initial here: _____

_____ _____

Signature of Patient or Authorized Representative Date

_____

Printed Name and Relationship

Therapist Signature _____ Date _____

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INFORMED CONSENT TO TREAT FOR ACUPUNCTURE

Acupuncture

I consent to the performance of acupuncture 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 named 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 this or any other office location, whether signatories to this form or not. Initials _____

I understand that treatment may include acupuncture, moxibustion, cupping, electrical stimulation, Chinese herbal medicine, nutritional counseling, massage and assisted stretching and range of motion movements. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. They may have an unpleasant smell or taste. I will notify a member of the studio staff of any unpleasant effects associated with the consumption of the herbs. Initials _____

I have been informed that acupuncture is a generally safe method of treatment but may have some side effects, including *bruising, numbness or tingling* near the needling sites that may last a few days, and *dizziness or fainting*. *Burns and/or scarring* are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. *Bruising* is a common side effect of cupping. *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.* Initials _____

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Initials _____

Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. **I will notify a therapist who is caring for me if I am or become pregnant.** Initials _____

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 based upon the facts then known, is in my best interest. I understand results are not guaranteed. Initials _____

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

I have read, or have had read to me, the above consent for 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.

_____ _____

Patient Signature (Or Patient Representative, indicate relationship if signing for patient) Date

_____ _____

Acupuncturist Signature

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INFORMED CONSENT TO TREAT FOR MASSAGE

Massage

I consent to the performance of massage, bodywork and other procedures within the scope of the practice of massage and bodywork therapy on me (or on the patient named below, for whom I am legally responsible) by the massage therapist named below and/or other licensed massage therapists who now or in the future treat me while employed by, working or associated with or serving as back-up for the therapist named below, including those working at the Heartwood Healing Collective or any other office or location, whether signatories to this form or not. Initials _____

I understand that treatment may include but is not limited to massage, moxibustion, guasha, cupping, electrical stimulation, luk pra kob (steamed herbal compresses), hydrotherapy, aromatherapy, assisted stretching and range of motion movements. *Burns and/or scarring* are a potential risk of moxibustion and cupping. *Bruising* is a common side effect of cupping and guasha. *Burns* may also be a rare side effect of hydrotherapy and LPK. I understand that I may feel sore for up to 72 hours after receiving a massage and in rare instances for longer periods of time. I understand it is is my responsibility to communicate any pain or discomfort I am experiencing to my therapist. Initials _____

I understand that bodywork and massage therapy are intended to reduce stress and provide relief from muscular tension, spasm or pain and enhance relaxation, improve circulation and offer a positive experience of touch. If I experience pain or discomfort I will immediately inform the massage therapist so that the pressure or methods may be adjusted to my comfort level. Initials _____

I understand that bodywork professionals do not diagnose illness or perform spinal manipulations. They also do not prescribe medical treatments and nothing said or done during a session should be construed as such. I understand that reference to Traditional Chinese Medicine patterns in the course of treatment does not constitute diagnosis or medical treatment. Initials _____

I acknowledge that massage and bodywork therapy is not a substitute for medical examination or diagnosis and that I should see a healthcare provider for those services. I have informed my therapists of all my known physical and medical conditions as wells as medications. Because bodywork should not be performed under certain circumstances, I agree to keep the therapist updated as to any changes in my health profile and I release this therapist or any future therapists working at this clinic or elsewhere of liability if I fail to do so. **I will notify a therapist who is caring for me if I am or become pregnant.**

_____ _____

Client Signature (Or Patient Representative, indicate relationship if signing for patient) Date

_____ _____

Therapist Signature Date