THUNDERBOLT WELLNESS
TRADITIONAL CHINESE MEDICINE
ACUPUNCTURE
CHINESE HERBOLOGY

Janet L. Borges, MSTCM, L.Ac.
8401 Patterson Avenue, Suite 103
Richmond, VA 23229

Welcome!

Thank you for the opportunity to work with you. I look forward to helping you create a healthier life. Attached you'll find information on my practice as well a New Patient Information Form. Please print and complete these documents and bring them to your first appointment.

The initial consultation is a very important part of traditional Chinese medicine (TCM) and extremely comprehensive. We will discuss your primary reason(s) for seeking treatment, review your health history, and take time to answer any questions you might have. You will also receive an acupuncture treatment during this first session. It is important to allow 1.5–2 hours for this visit. Return visits typically last 1–1.25 hours.

All fees are due at the time of service. Acceptable forms of payment are cash, checks, and major credit cards. The charge for the initial consultation and treatment is $160.00. Return office visits and treatments are $95.00. There is a 20% discount on the return visit fee for patients over 65 years, as well as Veterans of any age. Sometimes it may be necessary to increase the frequency of treatments to twice weekly, in which case the return visit fee is reduced, as is the length of the appointment.

If dietary supplements or Chinese medicinal formulas are part of your treatment plan, those formulas will be charged separately, and the cost varies. Sales tax is added.

Thunderbolt Wellness is located in the Tuckahoe neighborhood of Henrico County, between Forest Avenue and Parham Road, in the Glen Ridge Professional Building. Parking is available in front of the building. When you arrive, please make yourself comfortable in the reception area. Be sure to wear loose, comfortable clothing and eat a light meal 1–2 hours prior to your appointment time.

If for any reason you will not be able to keep your appointment, please provide at least 24 hours notice. (Please see Office Policies for more information). You may contact me via phone, text message, or email to do this.

Thank you again for choosing Thunderbolt Wellness.

I look forward to working with you!

Janet L. Borges, MSTCM, L.Ac.
Licensed Acupuncturist and Clinical Herbalist, Traditional Chinese Medicine

THUNDERBOLT WELLNESS

PRIVACY POLICY

This notice describes how health and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Section I. Uses & Disclosures for Treatment, Payment & Health Care Operations

A. We may use or disclose your protected health information (PHI) for treatment, payment, or health care operations purposed with your consent. To help clarify these terms here are some definitions:
   a. "PHI" refers to information in your health record that could identify you.
   b. "Treatment, Payment and Health Care Operations"
      i. *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would when we consult with another health care provider, such as your family physician or a specializing physician.
      ii. *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
      iii. *Health Care Operations* are activities, business-related matters such as audits and administrative services, and case management and care coordination.
   c. "Use" applies only to activities with our office/clinic/practice group, such as releasing, transferring or providing access to information about to other parties.
   d. "Disclosure" applies to activities outside our office/clinic/practice group/etc, such as releasing, transferring or providing access to information about you to other parties.

Section II. Uses and Disclosures Requiring Authorization

B. We may use or disclose PHI for purposes outside of treatment, payment, and healthcare operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and healthcare operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your medical records.

C. You may revoke all such authorization at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

Section III. Uses & Disclosures with Neither Consent nor Authorization

D. We may use or disclose PHI without your consent or authorization in the following circumstances:
   a. Child Abuse: If we have reason to suspect that a child is abused or neglected, we are required by law to report the matter immediately to the Virginia Department of Social Services.
   b. Adult and Domestic Abuse: If we have reason to suspect that an adult is abused, neglected or exploited, we are required by law to immediately make a report and provide relevant information to the Virginia Department of Welfare and Social Services.
   c. Health Oversight: The Virginia Board of Medicine has the power, when necessary, to subpoena relevant records should we the focus of an inquiry.
   d. Judicial or Administrative Proceedings: If you are involved in a court proceeding and request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information without the written authorization of you or your legal representative, or a subpoena (of which you have been served, along with the proper notice required by state law). However, if you move to quash the subpoena, we are required to place said records in a sealed envelope and provide them to the clerk of court of the appropriate jurisdiction so that the court can determine whether the records should be released. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
   e. Serious Threat to Health or Safety: If we are engaged in our professional duties and you communicate to us a specific and immediate threat to cause serious bodily injury or death, to an identified or to an

unidentified person, and we believe you have the intent and ability to carry out that threat immediately or imminently, we must take steps to protect third parties. These precautions may include (1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18; or (2) notifying a law enforcement officer.

f. Worker's Compensation: If you file a worker's compensation claim, we are required by law, upon request, to submit your relevant health information to you, your employer, the insurer, or a certified rehabilitation provider.

Section IV. Patient's Rights & Provider's Duties

E. Patient's Rights
   a. Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
   b. Right to Receive Confidential Communication by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations (Example: you may request your bill be sent to an alternate address.)
   c. Right to Inspect and Copy – You have the right to inspect and obtain a copy (or both) of PHI and bill records used to make decisions about you for as long as the PHI is maintained in the record (service charges and copy fees may apply.)
   d. Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request.
   e. Right to Accounting – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization. On request, we will discuss with you the detail of the accounting process.
   f. Right to a Paper Copy – You have the right to obtain a paper copy of the notice from our office/clinic, even if you have agreed to receive the notice electronically.

F. Health Provider's Duties:
   a. We are required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy policies and practices with respect to PHI.
   b. We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
   c. If we revise my policies and procedures, we will advise you of this change by posting that change in the waiting room.

Section V. Questions and Complaints

G. If you have questions about this notice or other concerns about your privacy rights, or if you have a complaint please contact Janet Borges, 8401 Patterson Avenue, Suite 103, Richmond, VA 23229. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. We can provide you with the appropriate address upon request.

H. You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

Section VI. Effective Date, Restrictions and Changes to Privacy Policy

I. This notice will go into effect on April 2004

J. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice by posting this information in the waiting room of the office.

THUNDERBOLT WELLNESS

GENERAL INFORMATION & OFFICE POLICIES

Office Hours: Patients are seen by appointment only and hours are subject to change. Please see the Thunderbolt Wellness website for current posted hours. All scheduling is done online via a click-through link on the homepage or via phone or email.

Patient Fees and Payment: Full payment is due at the time of service. Acceptable forms of payment are cash, checks and all major credit cards. (The fee for returned checks is $30.00.)

The fee for the Initial Consultation & Treatment is: $160.00. Return Visits for established patients are $95.00. If more than one treatment per week is scheduled, the fee is reduced, as is the length of the appointment. Initial Herbal Consultations without acupuncture are $130.00. Follow-up herbal consultations are $90.00. Herbal formulas and/or dietary supplements vary in price. Payment arrangements & need-based discounts may be available. There is a 20% discount on the regular return visit fee for those patients who are 65 and older, as well as Veterans of any age.

Insurance: Thunderbolt Wellness does not file insurance claims or accept third-party insurance payments. Upon request, you will be provided with a detailed receipt you can submit to your insurance carrier for reimbursement. Be sure to check with your insurance provider before submitting a claim for reimbursement. If you plan on submitting a claim, it is helpful to obtain the ICD (diagnosis) codes from your physician, which can be used with permission on the receipt. Acupuncture is a tax-deductible medical expense and you can also use funds from your Flexible Spending Account (FSA) or Health Savings Account (HSA).

Medical History: Please bring a completed copy of New Patient Information Form to our first visit, which is available for download via the Thunderbolt Wellness website. If you cannot download the forms, please advise, and they can be sent to you via email or post.

Medical Records: All personal information and medical records are confidential and secured to protect patient privacy. Thunderbolt Wellness does not share or keep electronic records. Personal and health information are only released or shared with your written permission or by court order. Patient records are maintained for 6 years (or as required by law) following the last patient visit after which they are destroyed in a manner that protects patient confidentiality, such as by incineration or shredding. At any time you may submit a written request to view your file and you may request a copy of your records (subject to copy fees, as dictated by Virginia law.)

Letters/Forms: Brief forms for insurance companies and/or attorneys that require a few minutes to complete will be free of charge. Forms requiring more than 15 minutes of time will be subject to an hourly fee of $90.00, billed in 30 minute increments, due upon completion.

Cell Phones: Please turn off your cell phone prior to scheduled appointment and leave your phone in the "off" or silent position during your appointment.

Prescription Medication & Drug Use: It is important that you inform me of any and all prescription medication you taking and that you inform me of any changes prior to treatment. If you are currently taking a prescribed pain medication, please inform me prior to scheduling an appointment. Please do NOT arrive to your appointment under the influence of any recreational drugs or alcohol.

Punctuality: I respect your time, and work diligently to start and finish each appointment on time. Please arrive a few minutes before your scheduled appointment. If you are more than 15 minutes late, we will have to reschedule your appointment.

Appointment Cancellation: Like most small business, this practice relies on each and every appointment, so please provide at least 24 hours' notice of cancellation. Appointments canceled without 24 hours' notice will be charged the full amount of the appointment.

THUNDERBOLT WELLNESS

NEW PATIENT INFORMATION FORM

CONTACT INFORMATION

Today's Date:

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.	Last Name	First Name	Middle In.

Please indicate if you want correspondence sent in a sealed envelope marked "CONFIDENTIAL." ☐YES ☐NO

Home Address			*Billing / Mailing Address*		
City	State	Zip Code	*City*	*State*	*Zip Code*
Email Address		Home Phone	Cell Phone	Other Phone	
Sex ☐ M ☐ F	Place of Birth:	Please indicate if confidential messages may be left.			
	Date of Birth:	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	
Marital Status	☐ Single ☐ Married ☐ Cohabitating ☐ Separated ☐ Divorced		Years Married or Cohabitating		
Education, Highest Level:		Occupation:	How long:		

RELEASE OF INFORMATION & EMERGENCY CONTACT INFORMATION

List an emergency contact and other persons to whom confidential information may be released.

Emergency Contact	**Relationship**	**Phone**
Other Name	**Relationship**	**Phone**
Address	**State**	**Zip**
Other Name	**Relationship**	**Phone**
Address	**State**	**Zip**

PATIENT AGREEMENT

I have received a copy of the office policies. I have read and understand these policies. I agree to adhere to all policies as well as any future alterations or changes to the office policies. I understand that payment is due at the time of service and agree to make full payment at that time. I understand that by scheduling an appointment for myself I am agreeing to pay for the time reserved as well as the professional service provided. I agree to provide the practice of Janet L. Borges, Licensed Acupuncturist with at least 24 hours notice when canceling a scheduled appointment. I understand that if I cancel an appointment without providing 24 hours notice I will be required to pay the normal cost of that appointment.

Signature:	*Date:*
Print Full Name:	

THUNDERBOLT WELLNESS

NEW PATIENT INFORMATION FORM

MAJOR COMPLAINT - WHAT IS YOUR PRIMARY REASON FOR THIS VISIT?

PHYSICIAN & REFERRAL INFORMATION

Where you referred by a physician?		
☐ YES	Name	Phone
	Please bring the written referral to your appointment or have your physician's office send it.	
☐ NO	Please be sure to complete the section of this form titled **…** ***Recommendation for Examination by a Physician.***	
Primary Health Care Provider:		Phone
Referred by (other):		

HAVE YOU EVER BEEN TREATED WITH TRADITIONAL CHINESE MEDICINE? (ACUPUNCTURE &/OR CHINESE HERBS)

☐ NO ☐ YES (If yes, please provide additional information)

FAMILY HISTORY

Father	☐ Alive – Describe present health:	
	☐ Deceased – Cause of death:	
Mother	☐ Alive – Describe present health	
	☐ Deceased – Cause of death:	
Brothers	Number alive:	Current health:
	Number deceased :	Cause of death:
Sisters	Number alive:	Current health:
	Number deceased:	Cause of death:
Children	Number alive:	Current health:
	Number deceased:	Cause of death:

THUNDERBOLT WELLNESS

NEW PATIENT INFORMATION FORM

PERSONAL MEDICAL HISTORY

How would you describe your health as a child?

Current Health

Height:	*Dressed weight:*	*How long at this weight:*

Check any illnesses or conditions you have or had in the past:

☐Diabetes ☐Glaucoma ☐Heart trouble ☐High blood pressure ☐Syphilis ☐Vein trouble ☐Cancer ☐Asthma ☐Jaundice
☐Gonorrhea ☐Bleeding tendencies ☐Tuberculosis ☐Mumps ☐Pneumonia ☐Allergies
☐Kidney disease ☐Rheumatic fever ☐Nervous disorder ☐Measles ☐Chicken pox ☐Meningitis ☐HIV
☐Multiple sclerosis ☐Mononucleosis ☐High fevers ☐Antibiotic uses ☐Hepatitis ☐Polio ☐Depression ☐Other

List hospitalizations and/or surgical operations (in &out-patient services)

Date	Doctor	Description

List any and all prescription medications you are currently taking. *Attach list at end if necessary

Medication & Dosage	Purpose	Length of use

List any cortisone type drugs you have taken. *Attach list at end if necessary

Medication & Dosage	Purpose	Length of use

List any and all dietary supplements you are currently taking. *Attach list at end if necessary

Supplement & Dosage	Purpose	Length of use

List any allergies or sensitivities to any medicines or other substances

Medication	Reaction

List any serious traumas, injuries, broken bones, scars etc.

Check the diseases against which you have been immunized:

☐ Small pox ☐ Tetanus ☐ Typhoid ☐ Influenza ☐ Polio ☐ Other:

Medical Exams and Testing

Test	Date of Last	Result
Physical Exam		
Blood Test		
Cholesterol Test		
HIV Test		
Prostate Exam		
Other		

~ FOR WOMEN ONLY ~

Medical Exams and Testing

Test	Date of Last	Result
Pelvic Exam		
Pap Smear		
Mammography		

Menstruation, Pregnancy and Menopause

Number of times pregnant:	Number of live births:
Number of miscarriages:	Number of pregnancy terminations:
Form of birth control:	Date of your last period:
Number of days normally from one period to the next:	
Describe flow and blood during period (Heavy, Light, Moderate Color of Blood (dark brown to red, etc) clots?):	
Pain or cramps during menstruation ☐ NO ☐ YES (If yes, please describe)	

Menstruation, Pregnancy and Menopause Cont.

Pre-menstrual problems ☐ NO ☐ YES (If yes, please describe)
Irregular/excessive periods ☐ NO ☐ YES (If yes, please describe)
Check all that apply ☐ Breast tenderness ☐ History of Ovarian Cysts ☐ Fibroids ☐ History of Endometriosis
Pre-menopausal symptoms ☐ NO ☐ YES (If yes, please describe)

Date of Menopause:	Menopausal symptoms ☐ NO ☐ YES (If yes, please describe)

General Health Habits

Exercise

Type	Times per week

Food & Drug Consumption

Alcohol	*x week*	Coffee	*x week*	Soda	*x week*	Smoking	*x week*

Recreational Drugs, *please list type(s) and duration and frequency of use:*
Particular food cravings *(sweet, salty, etc.):*

Describe any recent major life changes

Other General Wellness

Have you had more than one sex partner in the past 6 months? ☐ NO ☐ YES
Hours of sleep each night:
Describe general emotional state:

THUNDERBOLT WELLNESS

NEW PATIENT INFORMATION FORM

In the following boxes please check all that apply

☐Fatigue ☐Weight loss/Gain ☐Unexplained fever ☐Sleeping problems ☐Snoring ☐Allergic reactions ☐Family problems ☐Other

Upper Airways & Lungs, check all that apply

☐Nasal or sinus congestion ☐Post nasal drip ☐Hay fever ☐Voice change ☐Shortness of breath ☐Cough ☐Wheezing ☐Infection, serious or frequent ☐Sore throat ☐Other

Skin, check all that apply

☐Rash ☐Hives ☐Acne ☐Infection ☐Itching ☐Swollen glands ☐Lumps ☐Eczema/Psoriasis ☐Change in skin ☐Other

Stomach / Digestion, check all that apply

☐Appetite loss ☐Trouble Swallowing ☐Indigestion/heartburn ☐Nausea/vomiting ☐Abdominal Pain/discomfort ☐Excessive gas/bloating ☐Constipation ☐Diarrhea ☐Blood in stool ☐Hemorrhoids/rectal pain ☐Change in bowels ☐Excessive hunger ☐Other

Urination/Genitals, check all that apply

☐Change ☐Discomfort ☐Trouble starting to urinate ☐Dribbling after urination ☐Sudden need to urinate ☐Pain on urination ☐ Sexual Dysfunction ☐Abnormal discharge ☐ Pain on intercourse ☐Itching/dryness ☐Frequent nighttime urination ☐Jaundice or brown urine ☐Other

Hormones/Blood, check all that apply

☐Intolerance to cold ☐Hot flashes ☐Increased perspiration/sweating ☐Bruise easily ☐Abnormal bleeding ☐Muscle spasms ☐Dizziness when standing up ☐Other

Heart/Circulation , check all that apply

☐Chest tightness/heaviness/pain ☐Heart fluttering/racing/palpitations ☐Dizziness ☐Leg pain aggravated by exercise ☐Poor circulation ☐Blood pressure concern ☐Fainting ☐Other

Neurological/Psychological, check all that apply

☐Insomnia ☐Trouble falling asleep ☐Trouble staying asleep ☐Memory loss ☐Walking/coordination loss ☐Strength/coordination loss ☐Tingling/burning ☐Numbness ☐Shaking/tremor ☐Suicidal thoughts ☐Unusual thoughts ☐Chronic pain Concentration problems ☐Irritability increase ☐Lack of normal pleasure ☐Phobias/unusual concerns ☐Anxiety/low self-esteem ☐ Feelings of Hopelessness/despair ☐ Significant loss (death, job, divorce, financial etc.) ☐Other

Vision/Hearing, check all that apply

☐Pain ☐Change ☐Blurring/Doubling ☐Visual Obstructions “floaters” ☐ Ringing/buzzing in ears ☐Other

Head/Neck/Spine, check all that apply

☐Headaches ☐Migraines ☐Stiff/sore neck ☐Mid Back Pain ☐Low Backache ☐ Pain with sitting or standing ☐Recent injury (describe) ☐Other

Joints/Extremities, check all that apply

☐Swelling/pain ☐Redness/warmth ☐Varicose veins ☐Reduced movement ☐Nail/foot problems ☐Arthritis ☐Other

INFORMED CONSENT TO TREATMENT

I hereby request and consent to the performance of acupuncture and/or other treatments, defined as the *practice of acupuncture*, on me (or the patient named below, for whom I am legally responsible) by Licensed Acupuncturist, Janet L. Borges, with whom I have discussed the nature and purpose of my treatment.

I understand that acupuncture is performed by inserting very thin needles through the skin. Additional methods of treatment may include, but are not limited to: moxibustion (application of heat on or near the body's surface); cupping (suction cups applied to the skin); gua sha; electrical stimulation; breathing techniques; Tui-Na (Chinese massage); nutritional/dietary counseling; and the recommendation of herbal and/or nutritional supplements.

I have been informed that acupuncture is a safe method of treatment. Certain adverse side effects, while infrequent, may result, these include, but are not limited to: local bruising, numbness or tingling near the needling sites, minor bleeding, fainting, dizziness, and temporary pain or discomfort. I understand that I should not make significant movements while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping and gua sha. Infection is another possible risk, although the acupuncturist uses only sterile disposable needles and maintains a clean, safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes major risks of treatment, others may occur.

The herbal and/or nutritional supplements (which are from plant, mineral, and animal sources) that may be recommended, are traditionally considered safe in the practice of acupuncture and Chinese medicine, although some may be toxic in large doses. I understand that some herbal and/or nutritional supplements may be inappropriate during pregnancy. Some possible side effects of taking herbal and/or nutritional supplements are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that the herbal and/or nutritional supplements need to be prepared and consumed according to the written and oral instructions provided by the acupuncturist, and may have an unpleasant taste or smell. I will immediately notify the acupuncturist of any uncomfortable side effects associated with consumption of recommended herbal and/or nutritional supplements. I will notify the acupuncturist who is caring for me if I am or become pregnant.

I have truthfully disclosed all medical history including information regarding blood borne, contagious disease such as hepatitis (B, C) and HIV/AIDS_____ (your initials). Additionally, I will notify Janet L. Borges if I am or become pregnant_____(your initials).

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

Print Patient's Name _____ *Date* _____

Signature(Patient, Parent or Guardian) _____ *Date* _____

Recommendation for Examination by a Physician

I, Janet L. Borges, (VA Lic. # 0121000327), recommend to you, _____, that you be examined by a licensed Physician regarding the condition for which you are seeking acupuncture treatment.

I have read and understand this recommendation.

Patient Signature *Date*

Janet L. Borges, L.Ac.

Acupuncturist Signature *Date*

Please retain a copy of this Recommendation for Examination by a Physician for your records.
Virginia law requires that I give this form to you if I do not have written evidence that you have received a diagnostic exam in the last six months from a licensed practitioner of medicine, osteopathy, chiropractic or podiatry regarding the condition for which you are seeking treatment. ***(Code of Virginia §54.1-2956.9, 18 VAC 85-110-10).***

Patient Consent Use & Disclosure of Protected Health Information

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

I have received, read and understand the Notice of Privacy Practices and I authorize and consent to the use and disclosure of protected health information in manner described.

Print Patient Name

Patient Signature *Date*

Acupuncturist Signature *Date*

Janet L. Borges, L.Ac.