4370 S. Tamiami Trail, Sarasota, FL 34233
(Phone) 941-724-1884

**FINANCIAL POLICY**

Root Therapies, LLC makes complementary health care (as acupuncture and Chinese medicine) available to as many people as possible, at the most affordable rates. We love to treat you, and everyone else who walks through our doors. If it's not possible for you to make your appointment, please give us 24 hours' notice. All appointments that are cancelled or rescheduled with less than 24 hours' notice will be charged a $50 fee. Refunds on packages will be calculated by subtracting your package cost from the sessions you have used at $85/session. Patient will be responsible for all fees, including that which is not covered by insurance.
Thank you for your understanding!

## HIPAA Consent Agreement

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations.

I understand that as part of my health care that Root Therapies, LLC originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- as communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that my healthcare provider will use email, telephone and other sources to communicate with me. I understand that I will have the option of opting out of any emails pertaining to company newsletters, and that my information is kept confidential.

**CONSENT FOR TREATMENT**

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, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, acupuncture injection therapy, and nutritional counseling. 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 be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it 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.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) 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. Some possible side effects of taking herbs are nausea, gas, stomach ache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and 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.

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.

I hereby release Root Therapies, LLC, Dr. Jessica Fritz DACM (c), AP and Dr. Teresa Renfroe, DACM (c ), AP from any and all liability, which may occur in connection with the above-mentioned procedures. I understand I am free to withdraw this consent and discontinue participation at any time.

**Patient Name:**_____
(Or Patient Representative)

**Signature:**_____**Date:**_____

**Name of Minor:**_____**Relationship:**_____

**Physician Signature:**_____ **NPI#**_____**Lic#**_____