CLIENT CONSENT FORM & HIPAA PRIVACY NOTICE

I am aware that **Anisha Durve** is a nationally licensed Acupuncturist in the States of Florida and Ohio. She is also a nationally licensed Ayurvedic practitioner but there is currently no state licensure in the U.S. I understand she is not an allopathic physician and thus not qualified to make a medical diagnosis, prognosis, or recommendations based on conventional medical training. I understand Acupuncture or Ayurveda are not a substitute for appropriate medical care from a qualified physician, and it is my responsibility to consult my physician for my medical condition(s). All treatment and recommendations address energetic imbalances diagnosed in Traditional Chinese Medicine (TCM) or doshic imbalances diagnosed in Ayurvedic medicine, not treatment of "Western medical symptoms or conditions." Additionally, any examination techniques employed including measuring blood pressure and vital signs, shall only be evaluated from a TCM or Ayurvedic perspective, as opposed to a conventional medicine perspective. There is no implied or stated guarantee of success or effectiveness for any treatment, therapy, or recommendation. I have the choice to seek a second opinion from any other healthcare professional or to terminate treatment at any time.

I hereby request and consent to the performance of **acupuncture** treatments and other procedures within the scope of practice of TCM including but not limited to: acupuncture, acupressure, moxibustion (heat therapy), cupping, energy work, tui na (massage), herbal therapies, nutrition and lifestyle counseling. It is up to my sole discretion to follow any recommendations that are discussed with me. I will notify Anisha immediately if I am or become pregnant as this will affect treatment protocols. I will also notify her if I have a contagious disease such as AIDS, HIV, hepatitis, heart conditions, or bleeding disorders, etc. prior to beginning treatment. I am aware that the benefits of acupuncture could be decreased by certain medications and social habits such as alcohol, tobacco, steroids, narcotics, stimulants, antidepressants, psycho-pharmaceuticals, and illegal drugs. I also understand that if I am on blood thinners such as coumadin, etc. there is increased chance of bleeding due to needling. Drinking caffeine can potentially affect pulse diagnosis.

I realize there are some inherent risks from **TCM procedures** including but not limited to minor bruising, bleeding, numbness or tingling near the needling sites, broken needle, moxa burn or scarring, light-headedness, fainting, or dizziness. Infection is another possible risk, although the clinic uses only sterile disposable needles, maintains a clean and safe environment, and Anisha holds national certification in clean needle technique. Burns and/or scarring are a potential risk of moxibustion but can be avoided with the use of indirect moxa techniques that do not touch the skin. Bruising is a common side effect of cupping. Fainting or dizziness can be avoided if I avoid extreme hunger or exhaustion prior to treatment. Occasionally a treatment can produce a temporary flare-up of symptoms, but usually these are limited to no more than a couple days. I do not expect Anisha to be able to anticipate and explain all possible risks and complications of treatment. I understand that despite the major risks of treatment, other side effects and risks may occur and I will notify her of these immediately. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including pneumothorax. I will immediately notify the Acupuncturist of any suspected side effects of treatment that I experience.

I understand that the goal of **Ayurveda** consultations is to evaluate doshic imbalances based on my body type and discuss successful strategies for health maintenance and prevention of doshic imbalance. I am encouraged to discuss Ayurvedic care recommendations with my physician. Recommendations may include but are not limited to: existing doshic imbalances, lifestyle healthy habits, detoxification strategies, wellness concerns, stress management techniques (such as meditation, yoga, and breathwork), and dietary tips such as healthful use of culinary spices.

The **herbal remedies** that may be suggested are traditionally considered safe in the practice of TCM and Ayurveda, although some may be toxic in large doses. I understand that Acupuncturists and Ayurvedic practitioners are not trained in pharmacology and cannot provide guidance on usage or alteration of my medical prescriptions. It is my responsibility to consult with my physician prior to taking herbal remedies to discuss possible interactions with current medications prescribed by my physician. I understand that some herbs may be contraindicated during pregnancy. Some possible side effects of taking herbs include nausea, flatulence, abdominal pain, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

By signing below, I indicate I am aware of the risks of treatment and I agree to the conditions and terms as mentioned above. I acknowledge that if I have any questions or concerns regarding my care, I am encouraged to discuss this with Anisha. This consent form will cover treatment for the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I knowingly, voluntarily and expressly waive any claim I may have against Anisha Durve and Nirvani Healing Arts LLC, their agents or employees for any results or effects of treatments, herbal therapies, use of products, or medical advice. I, my heirs, or legal representatives, forever release, waive, discharge and covenant not to sue Anisha Durve and Nirvani Healing Arts LLC, or their agents or employees, for any results or effects from treatments, herbal therapies, use of products, or medical advice.

I AGREE TO THE ABOVE CONDITIONS PRIOR TO TREATMENT/ CONSULTATION.

_____	_____	_____
Printed Name	Signature ❒ Patient ❒ Parent/ Guardian	Date (Month, Day, Year)

CLIENT CONSENT FORM & HIPAA PRIVACY NOTICE

This notice describes how your medical information may be used and disclosed, and how you can get access to this information. Please review the information carefully.

- The organization is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information.
- The organization will promptly contact you should there be any breach of your protected health information.
- The organization will abide by the terms of this notice. The organization reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information.
- You may be contacted by the organization to remind you of any appointments.
- For further information about this Privacy Notice, please contact Anisha Durve DOM, president of Nirvani Healing Arts LLC. This notice is effective as of 4/1/16.

Your confidential healthcare information may be released to:

- Other healthcare professionals within the organization for the purpose of providing you with quality healthcare.
- Your insurance provider for the purpose of the organization receiving payment for providing you with needed healthcare services. (We do not take insurance at this time.)
- Public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Other healthcare providers in the event you need emergency care.
- Only after receiving written authorization from you. This provision includes but is not limited to any psychotherapy notes, for marketing purposes and any disclosure that may constitute a sale of your protected healthcare information. Any other uses or disclosures not described in this notice can only be made with your express authorization. You may revoke your permission to release confidential healthcare information at any time.
- Your confidential healthcare information may NOT be released for any other purpose than that which is identified in this notice.

Your Rights:

- You have the right to receive confidential communication about your health status.
- You have the right to review and photocopy any/all portions of your healthcare information.
- You have the right to make changes to your healthcare information.
- You have the right to know who has accessed your confidential healthcare information and for what purpose.
- You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.
- You have the right to restrict the use of your confidential healthcare information. However, the organization may chose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency.
- You have the right to opt out of notifications regarding healthcare treatment options, marketing and fundraising, or other health services that might be of interest to you.
- You have the right to complain to the organization if you believe your rights to privacy have been violated. If you feel your rights to your privacy have been violated. If you feel your privacy rights have been violated, please email your complaint to the organization: Nirvani Healing Arts LLC nirvani108@gmail.com. All complaints will be investigated. No personal issue will be raised for filing a complaint with the organization.

I hereby give my consent to Nirvani Healing Arts LLC and its employees to use and disclose my protected health information for the purposes of treatment, payment, and operations of my health care and this practice. I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. This consent includes contact and discussion with other healthcare providers for care and treatment. This release may include information about drug use/abuse, alcohol use/abuse, mental health issues or concerns, AIDs or HIV status as pertinent to my medical care.

I have reviewed the Practice Privacy Notice as part of this registration process. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. I understand that the terms of the Privacy Notice may change and I may obtain the revised notice by contacting Nirvani Healing Arts LLC. I understand that Nirvani Healing Arts LLC may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time. If I revoke this consent, the revocation does not take effect until the practice receives it.

_____ _____ _____

Printed Name Signature ❒ Patient ❒ Parent/ Guardian Date (Month, Day, Year)