

A WAY OF BEING
Financial Policy and Consent to Treatment

FINANCIAL POLICY

Providing you with EXCELLENT and AFFORDABLE health care is important to us. The following policy is designed to ensure that we will be able to continue doing so.

BILLING: Clients are expected to make payments at the time of service, unless payment arrangements have been approved of in advance by our staff. Payment can be in the form of check, cash, or credit card. If cash, please bring exact amount, as the front desk may not always be able to provide change.

INSURANCE: Tabitha does not currently accept insurance for massage, except in the case of medical massage for motor vehicle accidents. A doctor's referral will be required along with contact information for your insurance, a claim number, and date of injury. If your treatment is covered by health insurance and you would like to bill them, you may attach your receipt to a claim form and submit them to your insurance for reimbursement.

CANCELLATIONS: Individuals who give less than 24 hours notice will be charged a standard \$25 cancellation fee. No show or repeated last minute cancellations may be charged for the full session.

INFORMED CONSENT

Massage Therapy: Any massage treatment I receive is for the purpose of stress reduction, relief of muscular tension, spasm or pain, or for the increase of circulation or energy flow only. If I feel pain or discomfort, I will communicate with my practitioner immediately so that the appropriate adjustments in pressure or technique can be adjusted to my level of comfort. I have been made aware of certain possible side effects of massage including muscle soreness or aching and the possible aggravation of symptoms existing prior to treatment.

Everything we think or feel is reflected in our body so it is not unusual for old memories and feelings to surface during massage. I understand that this reaction is a normal response, and that I have the right to stop therapy at any time should I become uncomfortable. I understand that Massage Practitioners do not diagnose illness, disease or any mental or physical disorder; nor do they prescribe medical treatment, pharmaceuticals or provide spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis and it is recommended that I see a primary health care provider for that service.

Moxa, Gua Sha, & Cupping: like any healthcare treatment, moxa, gua sha, & cupping come with inherent risks. I understand that bruising, pain or injury may occur with these modalities as well as accidental burning or scarring from moxa or gua sha treatments.

I understand that I am responsible for reporting any changes to my medical information and my practitioner will not be held liable if I fail to do so. I have carefully read and understand the above information. I agree to the terms of the above financial policy and have given my permission and consent to treatment.

Signature: _____ Printed Name: _____ Date: _____

Signature of Guardian: _____ Printed Name: _____ Date: _____
(if applicable)

Notice of Privacy Practices

A Way of Being Wellness Center and *Tabitha Marsh, MA, LMT#5104* (referred to below as “This Practice”) are committed to protecting your private health information. Please review the following carefully.

Health information may include information created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for your treatment and care;
- refer to, consult with, coordinate among, and manage along with other health care providers within GroundSpring Healing Center, P.C., and/or other health care providers involved in your care and treatment including but not limited to your primary care physician.
- determine your eligibility to health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of your health care; and
- perform various office, administrative and business functions that support your health practitioner’s efforts to provide you with, arrange and be reimbursed for quality, cost-effective health care, and for quality control purposes.

In respect to your protected health information, you have the right:

- to request limits on the way your health information is used or disclosed. All requests must be made in writing and you must specify what information you want to limit and to whom you want the limits to apply. The Practice is not required by law to agree to such requests.
- to look at or get copies of your records. You must make the request in writing. We may charge you a reasonable fee based on copying and other costs. In certain situations, we may deny your request and will tell you why we are denying it.
- to request how confidential communications are provided to you. The Practice will attempt to accommodate any reasonable requests.
- to request a correction or an update of your records. You must make the request in writing and provide a reason for your request. The practice has the right to refuse your request.
- to request an accounting of any disclosures (not listed below) made of your information for six years prior to the date of your request. You must make this request in writing. The list will not include the releases of your information made for the purpose of treatment, payment, or health care operations. The list will not include information provided directly to you or your family, or information that was sent with your written authorization. It will also not include disclosures made prior to the effective date of the HIPPA privacy law (April 14, 2003), nor will it include disclosures made for national security, intelligence purposes, or law enforcement officers.
- to get a paper copy of the most recent version of this notice, if you request it. The most recent copy of this notice will be posed on this Practice’s website at *www.awayofbeing.net*.
- to withdraw your permission for us to release your information. If you sign an authorization to use or disclose information, you can revoke that authorization at any time. The revocation must be made in writing. This will not affect information that has already been used or disclosed.

The practice reserves the right to change its practices regarding the protected health information it maintains. If the Practice makes changes, it will update the Notice and make it available to you. The most recent copy of the Notice will be posted at the website at *www.awayofbeing.net*.

If you believe your privacy rights have been violated, you may file a complaint with this Practice or you may complain to the Secretary of the U.S. Department of Health and Human Services.

By signing below I agree that I have reviewed and understand the information above and that a copy of the Notice of Privacy Practices has been made available to me if I want it.

Signature: _____ Date: _____

