DISCLOSURE & CONSENT TO CHINESE MEDICAL TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture and Chinese Medicine on me (or on the patient so named, for whom I am legally responsible) by Whidbey Acupuncture + Herbs (the "Clinic"), Peter Lundeen, Lac. (the "Acupuncturist") and/or other licensed acupuncturists, students, or professionals who now or in the future treat me while employed by, working/associated with, apprenticing under, or serving as back-up for the Acupuncturist or the Clinic, I agree not to hold any of the above mentioned parties liable for any injury, side effect, complication, inconvenience, or problem, foreseeable or otherwise, that results from my being under the care of said parties.

I understand that my health care is ultimately my own responsibility, and that neither the Acupuncturist, nor the Clinic (and affiliated persons) are my primary care providers. I understand that it is my responsibility to seek treatment from my primary care provider if necessary.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, gua sha, bleeding, tui na, massage, manual therapy, Chinese herbal medicine (internal and external), qi gong, nutritional counseling, and lifestyle advice. I understand that the herbs may need to be prepared and consumed according to instructions provided orally and/or in writing.

I will immediately notify the Acupuncturist or a member of the clinic staff of any unanticipated or unpleasant effects associated with the consumption or use of herbs. I understand that Chinese medicine is generally a safe form of treatment, though side effects may include: bruising, numbness, tingling, swelling, headache, dizziness, or fainting. Cutaneous markings as a result of cupping or gua sha are desirable therapeutic results, not side effects. *V*ery rare side effects of acupuncture may include: spontaneous miscarriage, nerve damage, organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, even though this clinic uses sterile, single-use disposable needles, and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects may occur. The herbs and/or nutritional supplements (derived from plant, animal, or 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, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. Certain individuals may experience a skin reaction or irritation after using herbs internally or externally.

I will notify the Acupuncturist or a staff member of the Clinic immediately if I am, become, or may become pregnant.

I do not expect the Acupuncturist or Clinic staff 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, based upon the facts then known to determine what is in my best interest. I understand that results are not guaranteed.

I understand that 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.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I must provide this Notice to each client beginning no later than the date of our first service delivery to the client, including service delivered electronically, after April 14, 2003. I must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the client. I must also have the Notice available at the office for clients to request to take with them. I must post the Notice in our office in a clear and prominent location where it is reasonable to expect any clients seeking service from me to be able to read the Notice. Whenever the Notice is revised, I must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, I must distribute the Notice to each new client at the time of service delivery and to any person requesting a Notice. I must also post the revised Notice in our office as discussed above.

LEGAL DUTY

I am required by applicable federal and state law to maintain the privacy of your health information. I am also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. I must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/2003 and will remain in effect until we replace it. I reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. I reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that I maintain, including health information I created or received before I made the changes. Before I make a significant change in our privacy practices, I will change this Notice and make the new Notice available upon request You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice,

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR THE PURPOSE OF PROVIDING SERVICES

I use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: I may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: I may use and disclose your health information to obtain payment for services I provide to you.

Healthcare Operations: I may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, I cannot use or disclose your health information for any reason except those described in this Notice. To Your Family and Friends: I must disclose your health information to you, as described in the Client Rights section of this Notice. I may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: I may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, I will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, I will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. I will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information

Marketing Health-Related Services: I will not use your health information for marketing communications without your written authorization.

Required by Law: I may use or disclose your health information when I am required to do so by law. Abuse or Neglect: I may disclose your health information to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. I may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. National Security: I may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. I may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. I may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of an inmate or client under certain circumstances. Appointment Reminders: I may use or disclose your health information to provide you with appointment reminders (such as voicemail messages).

CLIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that I provide copies in a format other than photocopies. I will use the format you request unless I cannot practicably do so. (You must make a request in waiting to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. I will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, I will charge you $1.00 for each page to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative *f*ormat, I will charge a cost-based fee for providing your health information in that format. If you prefer, I will prepare a summary or an explanation of your health information for a

fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which I or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, I may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that I place additional restrictions on our use or disclosure of your health information. I am not required to agree to these additional restrictions, but if I do, I will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that I communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that I amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) I may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that I may have violated your privacy rights, or you disagree with a decision I made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice.

You also may submit a written complaint to the U.S. Department of Health and Human Services. I will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. I support your right to the privacy of your health information. I will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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