Victoria Ryan, L.Ac., LCSW, LADC

Drop In Acupuncture Program Participant Registration

Name: _____

Street Address: _____

City, State, Zip: _____

Home phone: _____Cell phone: _____

email address: _____DOB: _____

Reason for participation

_____

_____

List any medical conditions:

_____

Medications taken on a regular basis, dose and who prescribes them:

_____

_____

Primary Care Physician: _____

Psychiatrist: _____

Psychologist/Social Worker/other MH providers: _____

_____

I attest that the above information is accurate and understand it is my responsibility to provide updated information to Victoria Ryan should any information change.

Signed: _____ Date: _____

Print Name: _____

Auricular Acupuncture Consent for Treatment

Treatment Description:

The auricular acupuncture “acudetox” protocol is performed by placing 5 thin, sterilized needles on specific points of the outer ear. The treatment takes about 45 minutes and is administered by Victoria Ryan, licensed acupuncturist.

Possible Benefits of Treatment:

The use of the “acudetox” protocol for recovery support and relapse prevention has been shown to be helpful in relieving acute symptoms of withdrawal from a variety of substances. Individuals often feel immediate relief and a decrease in tension and anxiety. Further treatment may reduce such withdrawal symptoms as profuse sweating, headache, body ache, stomach pain, runny nose, drug dreams and cravings. Participants may develop a greater sense of and connection with themselves.

The protocol has been generalized to treat other conditions including stress/anxiety, ADD/DHD and PTSD and has the effects of decreasing tension and increasing relaxation, focus and sense of well being.

Voluntary treatment:

I hereby voluntarily consent to be treated with auricular acupuncture. I understand that I may be treated with acupuncture needles, seeds, balls and/or intradermal needles.

I have not been guaranteed any specific outcomes concerning the uses and effects of auricular acupuncture.

Possible Side Effects/Healing Reactions:

I understand that auricular acupuncture, though occurring rarely, may result in certain side effects including local bruising, slight bleeding, fainting, temporary pain and discomfort, and temporary aggravation of symptoms existing prior to treatment.

Conventional medicine therapy also may be indicated, either in response to an emergency or as deemed necessary at the discretion of a licensed health care practitioner.

Medical Referral:

I understand that if there is a worsening of an ailment or condition, or if a new ailment or condition arises, I should consult a licensed physician. I also understand that if I am currently under a physician’s care, I should continue as long as my physician and I deem it necessary. This program does not recommend altering medications or other therapies without first consulting my personal physician or health care provider.

Infectious Disease/Clean Needle Procedures:

I understand that there are infectious diseases which have the potential to be carried through the air, through physical contact, and through body fluids. I understand that the provider of this program follows strict precautions and uses only sterilized, prepackaged, disposable needles. The acupuncture needles that are used for this treatment are single-use and applied according to nationally-based professional standards.

By signing below I attest that I have read and agree to all of the above AND have received a Notice of Privacy Practices.

_____	_____	_____
Client Name	Client Signature	Date

Victoria Ryan, L.Ac., LCSW, LADC

Notice of Privacy Practices

This notice describes how health information about you is protected or may be used and disclosed and how you can gain access to this information. Please review it carefully.

Respect for patient privacy is highly valued. Confidentiality of all information that may reveal your identity will be maintained as required by law.

Required permission to use and disclose your protected health information (PHI)

I will obtain a one-time general written consent to use and disclose your health information in order to treat you, obtain payment for that treatment and conduct operations specific to my practice. This general written consent will be obtained the first time I provide you with treatment or services. This consent gives broad, general permission that does not need to be repeated each time I provide you with treatment or services. At times, other more specific consent may be obtained for particular services including, but not limited to providing acupuncture during the last weeks of pregnancy, or should specific information need to be disclosed to or obtained from a third party in effort to ensure that all providers are working together to ensure you receive appropriate care.

How I may use and disclose your health information

Health information about you is used for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care you receive. Health information about you may be disclosed to other practitioners for educational purposes or for continuity of service should another practitioner see you in my absence.

Your Rights

You have the right to look at health information about you. You may request in writing, to receive a copy of any information at a copying charge of ten (10) cents per page. If you believe that information in your record is incorrect, you have the right to request that such information be corrected.

My Legal Duty

I am required by law to protect the privacy of your information, provide this notice about my information sharing practices, follow such practices as described and seek your acknowledgement of this notice. You will be notified in writing of any significant changes in my personal policies or changes in policies dictated by law.

Please note that as a Mandated Reporter, I am required by law to report any suspect of child abuse, child endangerment or neglect to the proper authority.

Complaints

If you are concerned that I have violated your privacy rights or you disagree with a decision I made about access to your records, you may contact:

The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Telephone: 202-619-0257/877-696-6775