Beside Still Waters

Consent To Treat

I understand that most massage and bodywork techniques are traditionally performed with the client unclothed; however, I may absolutely decide what amount of clothing I prefer to wear for my own comfort. I understand that the therapist will leave the room while I undress and I relax on the table, and cover myself with a clean sheet and blanket provided to me. I will be properly covered at all times to keep warm and comfortable. Only the area being worked on will be uncovered.

The therapist and I have discussed the desired outcome of my session. I understand the areas of the body that will worked on and that I will not be touched on or near my genitals or breasts (manual lymph drainage for mastectomies may require special consent).

I have informed the therapist of any allergies to light oil or lotions that may be used. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I understand that as my body becomes more relaxed, pressure will gradually be increased to relax specific areas and relieve areas of muscular tension. I understand that the therapist will check with me from time to time about the pressure however I agree to communicate immediately if I feel any discomfort so that another approach may be taken. Massage is most effective when your body is not resisting.

I understand the average massage session lasts approximately one hour including a pre and post treatment assessment. A half hour appointment only allows time for a partial massage session, such as neck and shoulders, back, or legs and feet. Arriving early before my session will help me to relax and prepare myself for the treatment and assist in the relaxation process as well completing any required documents.

I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder, nor is it a substitute for a medical examination. Likewise, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor does she perform any spinal adjustments. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

(Continued on page 2)

LIGHTBODY MASSAGE
A balanced approach to mind, body and soul.

I have been informed that the following sometimes occur during massage are normal responses to relaxation. They include but are not limited to: the need to move or change position, sighing, yawning, change in breathing, stomach gurgling, emotional feelings and/or expression, movement of intestinal gas, energy shifts, falling asleep, memories.

I attest that the information I have provided is true and complete to the best of my knowledge and is confidential and will not be released without my written consent. I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

I consent to therapeutic massage treatment by Beside Still Waters and understand that I am responsible for any charges incurred in the course of my treatment. I understand that a 24 hour notice is required to reschedule all future appointments, or full charge may apply.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

HIPAA Privacy Authorization

Authorization for Use or Disclosure of Protected Health Information(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization

I authorize Beside Still Waters to use and disclose the protected health information described below.

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. □ ______________ to ______________.

OR

b. □ all past, present, and future periods.

3. Extent of Authorization

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. □ I authorize the release of my complete health record with the exception of the following information:

□ Mental health records

□ Communicable diseases (including HIV and AIDS)
□ Alcohol/drug abuse treatment
□ Other (please specify): ____
4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until __________________ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

NOTICE OF PRIVACY PRACTICE

This section describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have questions concerning this notice, please contact:

Carolyn Farrell at Beside Still Waters

206-778-7782 1besidestillwaters@gmail.com

We respect your privacy and understand that your medical information is personal and sensitive. Moreover, we are required by law to make sure that medical information that identifies you is kept private. This *Notice of Privacy Practices* describes how we may use or disclose your protected health information at our clinic. We are required to give you this notice of our legal duties and abide by the terms of this notice; however, we may change our notice at any time. **Please note that any new notice adopted will be effective for all protected health information maintained at the time of change.** You will not be notified individually if a change is made to our notice, however, upon request, we will provide you with a copy of our current notice. You may always obtain a copy of our current notice by any of the following means:

2. Contacting our office by mail, phone, or e-mail at the above address, phone number, and e-mail address
3. Asking for a copy at the time of your next visit

SECTION 1: We use and disclose your protected health information to carry out your treatment, obtain payment, and conduct health care operations.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes disclosures to other third parties that are involved in your health care elsewhere. Specifically, we would disclose your protected health information to other physicians who may be treating you when we have the necessary permission from you to do so. For example, your protected health information may be provided to a physician to whom you have been referred in order to ensure that the physician has the necessary information to diagnose and/or treat you. In addition, we may occasionally disclose your protected health information to another physician or health care provider, such as a medical specialist or laboratory, who becomes involved in your care by providing assistance with your health care diagnosis or treatment.
Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for coverage of future treatment with some medical modalities may require that your relevant medical information be disclosed to the health plan in order to obtain approval for future scheduling. Similarly, insurance companies may require that copies of your applicable medical records accompany any requests for payment of services already provided to you.

SECTION 2: Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

Per your Authorization: If you give us authorization to use or disclose your protected health information, you may revoke such authorizations at any time, in writing, except to the extent that our clinic has already taken action in reliance on the use or disclosure permitted in the authorization.
Legally Permitted/Opportunity to Object: We may use and disclose your protected health information in the following instances, but you will be given the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of such information, then we may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

1. To Others Involved in Your Healthcare: Unless you object, we may disclose your protected health information to a member of your family, a relative, a close friend or any other person you identify, to the extent the information directly relates to that person's involvement in your health care. For example, we may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care or your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.
2. In Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably possible after the delivery of treatment. If your physician or another physician in the practice must treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.
3. With Communication Barriers: We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances and the use or disclosure is done in accordance with other applicable laws.

Legally Permitted/No Opportunity to Object: We may use and disclose your protected health information in the following situations without your consent or authorization:

1. When Required by Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the applicable law(s) and will be limited to the relevant requirements of the law. You will be notified of any such uses or disclosures only if required by law.
2. For Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury, or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority. We may also disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
3. For Health Oversight/Compliance Monitoring: We may disclose your protected health information to a health oversight agency for activities

authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

4. Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child or dependent adult abuse or neglect. In addition, if we believe that you have been a victim of abuse, neglect, or domestic violence, we may disclose your protected health information to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

5. To the FDA: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

6. Legal Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal, in certain conditions in response to a subpoena, discovery request, or other lawful process.

7. Law Enforcement: We may disclose your protected health information for law enforcement purposes, so long as applicable legal requirements are met. Such purposes generally include: 1) those required by law; 2) limited information requests for identification and location purposes; 3) those pertaining to victims of a crime; 4) suspicion that death has occurred as a result of criminal conduct; 5) those where a crime occurs on the premises of the practice; and 6) medical emergencies where it is likely that a crime has occurred.

8. Research: We may disclose your protected health information to researchers when an institutional review board has approved their research. The institutional review board will have reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

9. Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel to authorized authorities; such as for determinations of your eligibility for benefits. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President, foreign heads of state, or others legally authorized.

10. Worker's Compensation: We may disclose your protected health information to comply with workers' compensation laws and other similar legally established programs.

11. Coroners, Funeral Directors, and Organ Donation: We may disclose your protected health information to a coroner, medical examiner, or funeral director, if necessary, for them to carry out their duties should you die.

12. Inmates: We may disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of a correctional facility or under the custody of a law enforcement official and your physician created or received your protected health information in the course of providing care to you. Such information may be released only for the following purposes: 1) to enable the correctional institution or law enforcement official to provide you with necessary healthcare services; 2) to protect your own health and safety or the safety of others; and 3) for the safety and security of the correctional institution.

SECTION 3: Specially-Protected Information

Special laws may restrict the use and disclosure of medical information related to mental health conditions, substance abuse, sexually transmitted diseases and HIV/AIDS. For example, we generally do not disclose specially protected information in response to a subpoena or other compulsory process unless: 1) you provide written authorization; or 2) a court orders the disclosure and mandates the necessary safeguards to protect the information after it is release.

SECTION 4: Your Rights

The following is a list of your rights with respect to your protected health information and a brief description of how you may exercise those rights. Should you have questions about this section or if you wish to exercise your rights, please contact the medical records office at the address listed on page one.

The right to inspect and obtain a copy of your protected health information. This means you may inspect and obtain a copy of the protected health information we maintain about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the institution use for making decisions about you. We may deny you access to some records as state and federal laws permit, however, if you are denied access, you may request a review or designate a health care provider with equal qualifications to receive the information instead.

The right to request a restriction on the use or disclosure of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment of healthcare operations as described in Section 1 of this notice. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes. Your request must be in writing and state the specific restriction requested and to whom or in what situation you want the restriction to apply. Please note that we are not required to agree to a restriction that you may request. If we believe it to be in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. However, if we agree to the requested restriction, we

may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with Carolyn Farrell.

The right to request that you receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request.

The right to request an amendment/correction to your health record. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request, you have the right to file a statement of disagreement with us, and the statement of disagreement you provide will be released along with the information challenged whenever it is released. We may also include a letter of rebuttal, which will also be released along with the challenged information. You are entitled to a copy of any letter of rebuttal we may place in your record.

The right to receive and accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this *Notice of Privacy Practices.* It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after November 1, 2011. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

The right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

SECTION 5: Complaints, Comments, and Inquiries

If you believe your privacy rights have been violated, you may report the suspected violation to us by contacting our clinic at (360) 863-2407 or by contacting the Secretary of Health and Human Services. We will take no punitive action against you for filing a complaint.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. Labor-stimulating techniques or any labor-inducing substances will not be used.

SIGNATURE PAGE

PATIENT'S NAME: ____ DOB: ____________

Name of person completing form if other than patient: ____________________________

Relationship to Patient: ____

PLEASE SIGN AND DATE ON ALL THE HIGHLIGHTED PORTIONS BELOW

PATIENT AUTHORIZATION AND UNDERSTANDING

I request that payment of benefits be made to Beside Still Waters and hereby authorize the release of any information necessary to determine the liability of payment and obtain reimbursement on any claim. I further authorize the use of my signature below on all insurance submissions for services rendered or to be rendered. I agree that a photocopy of this agreement shall be as valid as the original. This authorization shall remain valid until revoked by me in writing and there has been a termination of services with Beside Still Waters.

Patient's or Legal Guardian's Signature: __________________________________ Date: ________

CONSENT TO TREAT

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Beside Still Waters. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or a representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon request (see *Notice of Privacy Practices*) and that obtaining a copy of my record may require payment of a fee.

Patient's or Legal Guardian's Signature: __________________________________ Date: ________

HIPAA

I hereby certify that I have received & reviewed the *Notice of Privacy Practices* for Beside Still Waters. I understand that if I have objections or concerns with this policy, I must notify Beside Still Waters per the instructions in the *Notice of Privacy Practices*.

Patient's or Legal Guardian's Signature: __________________________________ Date: ________

CANCELLATION POLICY

I understand that if I do not give an 8 hour notice that I will be missing my appointment, that I may be charged 50% of the cost of my visit.

Patient's or Legal Guardian's Signature: __________________________________ Date: ________