Reiki Voluntary Consent and HIPPA Form

I hereby request and consent to Reiki treatment by Wendy Taylor, a Reiki Master. I understand that Reiki serves individuals with a wide range of complaints, including both acute and chronic healthcare issues. No guarantees concerning its use and effect are given to me.

I have been informed that Reiki is a safe method of treatment with no known side effects. I understand that Reiki is neither medical treatment nor massage, nor can it harm the body in any way. It does not interfere with traditional medical treatment. Reiki provides a natural source of restorative energy and relief from stress.

I understand that if there is an emergency, a worsening of my health condition, or a new ailment or condition arises, that I should consult a licensed physician.

I understand that administrative staff may review my patient records, but all of my records will be kept confidential and will not be released without my written consent. I understand that I have the right to request restrictions on certain uses and disclosures of my health information.

By voluntarily signing below, I show that I have read carefully, or have had read to me, this form and understand its provisions. I have felt free to ask any questions about this form and the proposed services and have received satisfactory explanations. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I understand that I am free to discontinue services at any time.

Payment & Cancellation Policy

In an effort to provide you with professional and personalized holistic healthcare, I reserve your appointment time exclusively for you. If you need to cancel or postpone your session, kindly call me at 202.997.0925 at least 24 hours in advance or else you will be charged the full fee for the missed session. Illness and family emergency are exempt. **If you are not feeling well the day of your session, please call me ahead of time to discuss whether it would be appropriate to receive treatment that day.** The charge for a returned check is $30.

_____

Printed Name of Patient Signature Date

_____

Address City State Zip

_____

Primary Phone – Circle one: cell home work Alternate Phone – Circle one: cell home work

_____

E-mail Address Date of Birth Occupation

I consent to receive appointment reminders via email: Yes___ No___ I wish to receive a newsletter via email:_____

Please email me occasionally about Reiki specials, Reiki classes, and similar updates: Yes___ No___

Found how:_____ Referred by: _____ May I thank them: Yes___ No___

Notice of Privacy Practices for Earley Wellness Group

The Health Insurance Portability and Accountability Act (HIPAA) requires that health care professionals give their clients a Notice of Privacy

Practices and that clients sign in acknowledgement that they received the notice.

Your health information will be routinely used for treatment, payment, and quality monitoring, and your consent, or the opportunity to agree or object, is not required in the following instances:

• Information obtained by your practitioner will be entered in your record and used to plan the course of treatment.

• Your record will be used to receive payment for services rendered by the practitioner(s) at Earley Wellness Group.

• This office will use your health information to assess the care you received and compare your treatment outcomes to others. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.

In addition, the following disclosures are required by law and do not require your consent:

• This office is required by law to disclose heath information to the Food and Drug Administration (FDA) related to any adverse effects of food, supplements, products, and product defects for surveillance to enable product recalls, repairs, or replacements.

• This office will release information to the extent authorized by law in matters of worker's compensation.

• This office is required by law to disclose health information in response to a valid subpoena for law enforcement purposes, as required under state or federal law.

• In the event that a member of this office believes in good faith that one or more patients, workers, or the general public are endangered due to suspect or clinical standards, provisions of federal law permit the disclosure of your health information to appropriate health oversight agencies, public health authorities, or attorneys.

• This office will disclose your health information in cases of domestic violence.

The following are considered routine uses and disclosures for which specific authorization will not be requested. You have the right to request restrictions on these uses. Otherwise, this office will request your authorization only when disclosure of personal health information is necessary to parties other than those referenced here.

• Using best judgment, a family member, close personal friend identified by you, personal representative, or other persons responsible for your care may be notified or given information about your care to assist them in enhancing your well-being or to confirm your whereabouts.

• This office may send information to you about health-related issues that you may find useful. Only your name and address will be used.

I acknowledge may voluntarily consent to treatment, and that I have received and understand this Notice of Privacy Practices.

Signature: _____Date_____