



INTEGRATIVE HEALTH, INC. WELLNESS CENTER

EXPERTS PROVIDING NATURAL HEALTHCARE

I, _____ understand Integrative Health Wellness Center is a wellness building that houses a variety of health professional businesses. As a patient you realize you are not being treated by Integrative Health Inc., but the specific provider's business you are seen by. Integrative Health is not your health care provider and cannot be held responsible to any harm or damages to your person.

By signing this form you understand the stated fact and release Integrative Health Inc. from any damages that could occur to my person.

Print Full Name

Signature

Date _____

BRIAN BOWEN, LAC
PROVIDER NOTICE OF PRIVACY PRACTICES

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY. Brian Bowen, L.AC. AND ALL OTHER HEALTH CARE PROVIDERS ARE REQUIRED TO INFORM YOU, THE PATIENT, HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. THE FOLLOWING ALSO OUTLINES HOW YOU CAN ACCESS YOUR HEALTH CARE INFORMATION.

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN BELOW.

As your healthcare provider, I use your health information for evaluation, treatment, to obtain payment for treatment and to evaluate the quality of care that you receive. If you are referred to another health care provider, or at your request, your medical records may be shared with those providers via paper mail, electronic mail, fax or other methods.

We may use your health care information without your authorization for the following reasons:

1. Public health safety
2. Auditing purposes
3. Emergencies
4. At the request of your insurance carrier
5. When required by law

In all other circumstances, we will ask your written permission to release your medical information in the form of a "Release of Medical Records" form. If you choose to sign such a form, you have the right to revoke that authorization at any time.

If at any time we change our policies in regard to your medical information, you will be informed with a new "Notice of Privacy Practices" form and will be asked to sign it.

You have the right to view and obtain a copy of your medical record. You also have the right to know to whom we have disclosed your medical records. If you believe the information in your medical record is not correct or missing information, you have the right to request that such information is corrected or added to your medical record.

If you have any questions or concerns about your medical records, please contact Integrative Health, Inc. at 303-577-9977, or you can file a written complaint with the U.S. Department of Health and Human Services. Integrative Health, Inc. is required by law to protect your medical information and to provide this notice to you, along with your signature acknowledging your receipt of this information.

AUTHORIZATION TO RELEASE INFORMATION

I authorize Integrative Health, Inc. to release any information required to process this claim to any insurance company or attorney in this case. I also authorized any insurance company or medical provider to release my medical records to Integrative Health, Inc. This information is to be used for the purpose of processing my claim for benefits due. I hereby agree that a photocopy of the document is as valid and effective as the original copy.

PAYMENT AGREEMENT

I hereby authorize my insurance benefits to be paid directly to Brian Bowen, L.Ac. I assume full responsibility for and agree to pay all costs, charges, and expenses of every kind and description for services furnished by Brian Bowen, L.Ac. I must pay charges and services not covered by any insurance or other third-party payer and/or not paid to Brian Bowen, L.Ac. for any reason within a time period Brian Bowen, L.Ac. deems reasonable. The amount of the bill shall be due and payable upon presentation to the patient, his/her agent, guardian, conservator or third-party responsible for payment of the charges.

CANCELLATION NOTICE

Kindly give 24 HOURS NOTICE for cancellations. Late cancellations are subject to 50% CANCELLATION FEE, no shows or cancellation with less than 2 hours before scheduled appointment are subject to a 100% CANCELLATION FEE. Cancellation fee is based on the cash rate of service. Call-backs or email reminders are a courtesy and I understand that I am responsible for my appointment and providing 24 hour notice for cancellations or reschedules.

Patient's Name (Print): _____

Signature: _____ Date Signed: _____

BRIAN BOWEN, LAC
Colorado Mandatory Disclosure and Consent Form for Acupuncture

Acupuncture has been explained to me as a treatment consisting of the insertion of needles through the skin at specific points on the surface of the body, by well-trained, licensed acupuncturists. Acupressure, acupuncture, moxabustion, cupping, allergy elimination technique, nutritional or herbal counseling are considered experimental procedures and are not considered a substitute for Western Medicine. Therapies and advice offered shall not be construed by the client to be a diagnosis or treatment of any disease or injury.

I understand that complications may result from acupuncture treatment. Among these possible complications are areas of anesthesia, fainting, weakness, nausea, hematoma, infection, pain and discomfort, pneumothorax, and aggravation of present symptoms. Being hungry, tired, or stressed can infrequently make the body more sensitive to the acupuncture treatment. Please tell your provider if you have any conditions that may inhibit blood clotting, such as hemophilia, or coumadin use. Please use caution walking with bare feet in the treatment room. I, the patient, further understand and agree to hold harmless, indemnify and protect against court action the individual acupuncturist/therapist as well as the management and owners of this clinic, in the event of accidental injury on these premises.

We gladly accept auto claims, workman's comp, and insurance as payment. Insurance coverage depends on your plan. Please call head of time to find out what your acupuncture benefits are.

Colorado law requires all acupuncturists provide the following information to clients on their first visit:

Education, Experience, Degrees, Certificates, Credentials, Licenses, Certificates, and Registrations:

Brian Bowen, L.Ac. has been licensed by the state of Colorado, which requires that she graduate from an approved institution (a four year program), and pass the National Board Exam (NCCAOM) for acupuncture and oriental medicine. Brian Bowen, L.Ac. has never had any license, registration, or certification issued by any local, state or national healthcare agency, revoked or suspended.

Cash Fee Schedule:

Initial Acupuncture Treatment (incl. exam).....	\$120.00*
Follow-up Acupuncture Treatment.....	\$80.00*
5-visit Family Plan.....	\$375.00
10-visit Family Plan.....	\$700.00
20-visit Family Plan.....	\$1300.00

Insurance Fee Schedule:

Each insurance company is different.

*Coupons or other special discounts may apply. All fees are due on the date of service. Family plan refunds: total paid less \$80 per treatment received. There are no expiration dates on family plans. Any questions about billing should be discussed with your provider.

This office complies with all rules and regulations promulgated by the Colorado Department of Health related to the proper cleaning and sterilization of needles used in the practice of acupuncture and the sanitation of acupuncture offices. This office uses only single-use disposable needles, and disposes of them in a manner consistent with OSHA and Colorado State regulations. We are trained in the recommendation and application of adjunctive therapies and herbs as defined by traditional Oriental medicine concepts

Each patient who visits this office is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.

In a professional relationship sexual intimacy is never appropriate and should be reported to the Director of the Divisions of Registrations in the Department of Regulatory Agencies: The Colorado Department of Regulatory Agencies regulates the practice of acupuncture. Send inquiries to the attention of: Director of the Division of Registrations 1560 Broadway, Suite 1545 Denver, CO 80202. Phone: (303) 894-2464. Each patient may seek a second opinion from another healthcare professional or may terminate therapy at any time. If you have any questions about any part of your treatments, billing statements, etc., please ask the office manager and tell your provider.

I have read and understand the above disclosure statement. I understand my rights and responsibilities as a patient.

Patient's Name (Print): _____

Signature of patient or legal guardian

Date Signed

NATALIE ZAJAC, LAC
PROVIDER NOTICE OF PRIVACY PRACTICES

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY. NATALIE ZAJAC, L.AC. AND ALL OTHER HEALTHCARE PROVIDERS ARE REQUIRED TO INFORM YOU, THE PATIENT, HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. THE FOLLOWING ALSO OUTLINES HOW YOU CAN ACCESS YOUR HEALTH CARE INFORMATION.

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN BELOW.

As your healthcare provider, I use your health information for evaluation, treatment, to obtain payment for treatment and to evaluate the quality of care that you receive. If you are referred to another health care provider, or at your request, your medical records may be shared with those providers via paper mail, electronic mail, fax or other methods.

We may use your health care information without your authorization for the following reasons:

6. Public health safety
7. Auditing purposes
8. Emergencies
9. At the request of your insurance carrier
10. When required by law

In all other circumstances, we will ask your written permission to release your medical information in the form of a "Release of Medical Records" form. If you choose to sign such a form, you have the right to revoke that authorization at any time.

If at any time we change our policies in regard to your medical information, you will be informed with a new "Notice of Privacy Practices" form and will be asked to sign it.

You have the right to view and obtain a copy of your medical record. You also have the right to know to whom we have disclosed your medical records. If you believe the information in your medical record is not correct or missing information, you have the right to request that such information is corrected or added to your medical record.

If you have any questions or concerns about your medical records, please contact Integrative Health, Inc. at 303-577-9977, or you can file a written complaint with the U.S. Department of Health and Human Services. Integrative Health, Inc. is required by law to protect your medical information and to provide this notice to you, along with your signature acknowledging your receipt of this information.

AUTHORIZATION TO RELEASE INFORMATION

I authorize Integrative Health, Inc. to release any information required to process this claim to any insurance company or attorney in this case. I also authorized any insurance company or medical provider to release my medical records to Integrative Health, Inc. This information is to be used for the purpose of processing my claim for benefits due. I hereby agree that a photocopy of the document is as valid and effective as the original copy.

PAYMENT AGREEMENT

I hereby authorize my insurance benefits to be paid directly to Natalie Zajac, L.Ac. I assume full responsibility for and agree to pay all costs, charges, and expenses of every kind and description for services furnished by Natalie Zajac, L.Ac. I must pay charges and services not covered by any insurance or other third-party payer and/or not paid to Natalie Zajac, L.Ac. for any reason within a time period Natalie Zajac, L.Ac. deems reasonable. The amount of the bill shall be due and payable upon presentation to the patient, his/her agent, guardian, conservator or third-party responsible for payment of the charges.

CANCELLATION NOTICE

Kindly give 24 HOURS NOTICE for cancellations. Late cancellations are subject to 50% CANCELLATION FEE, no shows or cancellation with less than 2 hours before scheduled appointment are subject to a 100% CANCELLATION FEE. Cancellation fee is based on the cash rate of service. Call-backs or email reminders are a courtesy and I understand that I am responsible for my appointment and providing 24 hour notice for cancellations or reschedules.

Patient's Name (Print): _____

Signature: _____ Date Signed: _____

NATALIE ZAJAC, LAC
Colorado Mandatory Disclosure and Consent Form for Acupuncture

Acupuncture has been explained to me as a treatment consisting of the insertion of needles through the skin at specific points on the surface of the body, by well-trained, licensed acupuncturists. Acupressure, acupuncture, moxabustion, cupping, allergy elimination technique, nutritional or herbal counseling are considered experimental procedures and are not considered a substitute for Western Medicine. Therapies and advice offered shall not be construed by the client to be a diagnosis or treatment of any disease or injury.

I understand that complications may result from acupuncture treatment. Among these possible complications are areas of anesthesia, fainting, weakness, nausea, hematoma, infection, pain and discomfort, pneumothorax, and aggravation of present symptoms. Being hungry, tired, or stressed can infrequently make the body more sensitive to the acupuncture treatment. Please tell your provider if you have any conditions that may inhibit blood clotting, such as hemophilia, or coumadin use. Please use caution walking with bare feet in the treatment room. I, the patient, further understand and agree to hold harmless, indemnify and protect against court action the individual acupuncturist/therapist as well as the management and owners of this clinic, in the event of accidental injury on these premises.

We gladly accept auto claims, workman's comp, and insurance as payment. Insurance coverage depends on your plan. Please call head of time to find out what your acupuncture benefits are. Colorado law requires all acupuncturists provide the following information to clients on their first visit:

Education, Experience, Degrees, Certificates, Credentials, Licenses, Certificates, and Registrations:

Natalie Zajac, L.Ac. has been licensed by the state of Colorado, which requires that she graduated from an approved institution (a four year program), and pass the National Board Exam (NCCAOM) for acupuncture and oriental medicine. Natalie Zajac, L.Ac. has never had any license, registration, or certification issued by any local, state or national healthcare agency, revoked or suspended.

*Cash Fee Schedule:

Initial Acupuncture Treatment (incl. exam).....	\$120.00
Follow-up Acupuncture Treatment.....	\$80.00
5-visit Family Plan.....	\$375.00
10-visit Family Plan.....	\$700.00
20-visit Family Plan.....	\$1300.00
IVF before & after embryo transfer treatments.....	\$300.00

*All fees are due on date of service. Family plan refunds: total paid less \$80 per treatment received. There are no expiration dates on family plans. Any questions about billing should be discussed with your provider.

* IVF/ IUI discount packages:

1. Initial acupuncture treatment, 8 follow-up treatments, and before & after embryo transfer treatments at fertility clinic: \$900 (regularly \$1060)
2. Initial acupuncture treatment, 20 follow-up treatments, and before & after embryo transfer treatments at fertility clinic: \$1700 (regular price: \$2020)

Insurance Fee Schedule: Each insurance company is different. Please call your insurance company regarding acupuncture coverage. Please ask about your deductible, co-pay, and any limits on the number of treatments.

This office complies with all rules and regulations promulgated by the Colorado Department of Health related to the proper cleaning and sterilization of needles used in the practice of acupuncture and the sanitation of acupuncture offices. This office uses only single-use disposable needles, and disposes of them in a manner consistent with OSHA and Colorado State regulations. We are trained in the recommendation and application of adjunctive therapies and herbs as defined by traditional Oriental medicine concepts

Each patient who visits this office is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.

In a professional relationship sexual intimacy is never appropriate and should be reported to the Director of the Divisions of Registrations in the Department of Regulatory Agencies: The Colorado Department of Regulatory Agencies regulates the practice of acupuncture. Send inquiries to the attention of: Director of the Division of Registrations 1560 Broadway, Suite 1545 Denver, CO 80202. Phone: (303) 894-2464. Each patient may seek a second opinion from another healthcare professional or may terminate therapy at any time. If you have any questions about any part of your treatments, billing statements, etc., please ask the office manager and tell your provider.

I have read and understand the above disclosure statement. I understand my rights and responsibilities as a patient.

Patient's Name (Print): _____

Signature of patient or legal guardian

Date Signed

TESS YAMADA, LAC
PROVIDER NOTICE OF PRIVACY PRACTICES

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY. Tess Yamada, L.Ac AND ALL OTHER HEALTHCARE PROVIDERS ARE REQUIRED TO INFORM YOU, THE PATIENT, HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. THE FOLLOWING ALSO OUTLINES HOW YOU CAN ACCESS YOUR HEALTH CARE INFORMATION.

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN BELOW.

As your healthcare provider, I use your health information for evaluation, treatment, to obtain payment for treatment and to evaluate the quality of care that you receive. If you are referred to another health care provider, or at your request, your medical records may be shared with those providers via paper mail, electronic mail, fax or other methods.

We may use your health care information without your authorization for the following reasons:

1. Public health safety
2. Auditing purposes
3. Emergencies
4. At the request of your insurance carrier
5. When required by law

In all other circumstances, we will ask your written permission to release your medical information in the form of a "Release of Medical Records" form. If you choose to sign such a form, you have the right to revoke that authorization at any time.

If at any time we change our policies in regard to your medical information, you will be informed with a new "Notice of Privacy Practices" form and will be asked to sign it.

You have the right to view and obtain a copy of your medical record. You also have the right to know to whom we have disclosed your medical records. If you believe the information in your medical record is not correct or missing information, you have the right to request that such information is corrected or added to your medical record.

If you have any questions or concerns about your medical records, please contact Integrative Health, Inc. at 303-577-9977, or you can file a written complaint with the U.S. Department of Health and Human Services. Integrative Health, Inc. is required by law to protect your medical information and to provide this notice to you, along with your signature acknowledging your receipt of this information.

AUTHORIZATION TO RELEASE INFORMATION

I authorize Integrative Health, Inc. to release any information required to process this claim to any insurance company or attorney in this case. I also authorized any insurance company or medical provider to release my medical records to Integrative Health, Inc. This information is to be used for the purpose of processing my claim for benefits due. I hereby agree that a photocopy of the document is as valid and effective as the original copy.

PAYMENT AGREEMENT

I hereby authorize my insurance benefits to be paid directly to Tess Yamada, L.Ac. I assume full responsibility for and agree to pay all costs, charges, and expenses of every kind and description for services furnished by Tess Yamada, L.Ac. I must pay charges and services not covered by any insurance or other third-party payer and/or not paid to Tess Yamada, L.Ac for any reason within a time period Tess Yamada, L.Ac deems reasonable. The amount of the bill shall be due and payable upon presentation to the patient, his/her agent, guardian, conservator or third-party responsible for payment of the charges.

CANCELLATION NOTICE

Kindly give 24 HOURS NOTICE for cancellations. Late cancellations are subject to 50% CANCELLATION FEE, no shows or cancellation with less than 2 hours before scheduled appointment are subject to a 100% CANCELLATION FEE. Cancellation fee is based on the cash rate of service. Call-backs or email reminders are a courtesy and I understand that I am responsible for my appointment and providing 24 hour notice for cancellations or reschedules.

Patient's Name (Print): _____

Signature: _____ Date Signed: _____

TESS YAMADA, LAC
Colorado Mandatory Disclosure and Consent Form for Acupuncture

Acupuncture has been explained to me as a treatment consisting of the insertion of needles through the skin at specific points on the surface of the body, by well-trained, licensed acupuncturists. Acupressure, acupuncture, moxabustion, cupping, allergy elimination technique, nutritional or herbal counseling are considered experimental procedures and are not considered a substitute for Western Medicine. Therapies and advice offered shall not be construed by the client to be a diagnosis or treatment of any disease or injury.

I understand that complications may result from acupuncture treatment. Among these possible complications are areas of anesthesia, fainting, weakness, nausea, hematoma, infection, pain and discomfort, pneumothorax, and aggravation of present symptoms. Being hungry, tired, or stressed can infrequently make the body more sensitive to the acupuncture treatment. Please tell your provider if you have any conditions that may inhibit blood clotting, such as hemophilia, or coumadin use. Please use caution walking with bare feet in the treatment room. I, the patient, further understand and agree to hold harmless, indemnify and protect against court action the individual acupuncturist/therapist as well as the management and owners of this clinic, in the event of accidental injury on these premises.

We gladly accept auto claims, workman's comp, and insurance as payment. Insurance coverage depends on your plan. Please call head of time to find out what your acupuncture benefits are.

Colorado law requires all acupuncturists provide the following information to clients on their first visit:

Education, Experience, Degrees, Certificates, Credentials, Licenses, Certificates, and Registrations:

Tess Yamada, L.Ac has been licensed by the state of Colorado, which requires that she graduate from an approved institution (a four year program), and pass the National Board Exam (NCCAOM) for acupuncture and oriental medicine. Tess Yamada, L.Ac. has never had any license, registration, or certification issued by any local, state or national healthcare agency, revoked or suspended.

Cash Fee Schedule:

Initial Acupuncture Treatment (incl. exam).....	\$120.00*
Follow-up Acupuncture Treatment.....	\$80.00*
5-visit Family Plan.....	\$375.00
10-visit Family Plan.....	\$700.00
20-visit Family Plan.....	\$1300.00

Insurance Fee Schedule:

Each insurance company is different.

*Coupons or other special discounts may apply. All fees are due on the date of service. Family plan refunds: total paid less \$80 per treatment received. There are no expiration dates on family plans. Any questions about billing should be discussed with your provider.

This office complies with all rules and regulations promulgated by the Colorado Department of Health related to the proper cleaning and sterilization of needles used in the practice of acupuncture and the sanitation of acupuncture offices. This office uses only single-use disposable needles, and disposes of them in a manner consistent with OSHA and Colorado State regulations. We are trained in the recommendation and application of adjunctive therapies and herbs as defined by traditional Oriental medicine concepts

Each patient who visits this office is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.

In a professional relationship sexual intimacy is never appropriate and should be reported to the Director of the Divisions of Registrations in the Department of Regulatory Agencies: The Colorado Department of Regulatory Agencies regulates the practice of acupuncture. Send inquiries to the attention of: Director of the Division of Registrations 1560 Broadway, Suite 1545 Denver, CO 80202. Phone: (303) 894-2464. Each patient may seek a second opinion from another healthcare professional or may terminate therapy at any time. If you have any questions about any part of your treatments, billing statements, etc., please ask the office manager and tell your provider.

I have read and understand the above disclosure statement. I understand my rights and responsibilities as a patient.

Patient's Name (Print): _____

Signature of patient or legal guardian

Date Signed

Tess Yamada, L.Ac. 303-577-9977
Integrative Health, Inc 5191 S. Yosemite, Suite B Greenwood Village, CO 80111

KIM LEBRUN, LAC
PROVIDER NOTICE OF PRIVACY PRACTICES

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY. KIM LEBRUN, L.AC. AND ALL OTHER HEALTHCARE PROVIDERS ARE REQUIRED TO INFORM YOU, THE PATIENT, HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. THE FOLLOWING ALSO OUTLINES HOW YOU CAN ACCESS YOUR HEALTH CARE INFORMATION.

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN BELOW.

As your healthcare provider, I use your health information for evaluation, treatment, to obtain payment for treatment and to evaluate the quality of care that you receive. If you are referred to another health care provider, or at your request, your medical records may be shared with those providers via paper mail, electronic mail, fax or other methods.

We may use your health care information without your authorization for the following reasons:

1. Public health safety
2. Auditing purposes
3. Emergencies
4. At the request of your insurance carrier
5. When required by law

In all other circumstances, we will ask your written permission to release your medical information in the form of a "Release of Medical Records" form. If you choose to sign such a form, you have the right to revoke that authorization at any time.

If at any time we change our policies in regard to your medical information, you will be informed with a new "Notice of Privacy Practices" form and will be asked to sign it.

You have the right to view and obtain a copy of your medical record. You also have the right to know to whom we have disclosed your medical records. If you believe the information in your medical record is not correct or missing information, you have the right to request that such information is corrected or added to your medical record.

If you have any questions or concerns about your medical records, please contact Integrative Health, Inc. at 303-577-9977, or you can file a written complaint with the U.S. Department of Health and Human Services. Integrative Health, Inc. is required by law to protect your medical information and to provide this notice to you, along with your signature acknowledging your receipt of this information.

AUTHORIZATION TO RELEASE INFORMATION

I authorize Integrative Health, Inc. to release any information required to process this claim to any insurance company or attorney in this case. I also authorized any insurance company or medical provider to release my medical records to Integrative Health, Inc. This information is to be used for the purpose of processing my claim for benefits due. I hereby agree that a photocopy of the document is as valid and effective as the original copy.

PAYMENT AGREEMENT

I hereby authorize my insurance benefits to be paid directly to Kim LeBrun, L.Ac. I assume full responsibility for and agree to pay all costs, charges, and expenses of every kind and description for services furnished by Kim LeBrun, L.Ac. I must pay charges and services not covered by any insurance or other third-party payer and/or not paid to Kim LeBrun, L.Ac. for any reason within a time period Kim LeBrun, L.Ac. deems reasonable. The amount of the bill shall be due and payable upon presentation to the patient, his/her agent, guardian, conservator or third-party responsible for payment of the charges.

CANCELLATION NOTICE

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Patient's Name (Print): _____

Signature: _____ Date Signed: _____

KIM LEBRUN, LAC
Colorado Mandatory Disclosure and Consent Form for Acupuncture

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We gladly accept auto claims, workman's comp, and insurance as payment. Insurance coverage depends on your plan. Please call head of time to find out what your acupuncture benefits are.

Colorado law requires all acupuncturists provide the following information to clients on their first visit:

Education, Experience, Degrees, Certificates, Credentials, Licenses, Certificates, and Registrations:

Kim LeBrun, L.Ac has been licensed by the state of Colorado, which requires that she graduate from an approved institution (a four year program), and pass the National Board Exam (NCCAOM) for acupuncture and oriental medicine. Kim LeBrun, L.Ac. has never had any license, registration, or certification issued by any local, state or national healthcare agency, revoked or suspended.

Cash Fee Schedule:

Initial Acupuncture Treatment (incl. exam).....	\$120.00*
Follow-up Acupuncture Treatment.....	\$80.00*
5-visit Family Plan.....	\$375.00
10-visit Family Plan.....	\$700.00
20-visit Family Plan.....	\$1300.00

Insurance Fee Schedule:

Each insurance company is different.

*Coupons or other special discounts may apply. All fees are due on the date of service. Family plan refunds: total paid less \$80 per treatment received. There are no expiration dates on family plans. Any questions about billing should be discussed with your provider.

This office complies with all rules and regulations promulgated by the Colorado Department of Health related to the proper cleaning and sterilization of needles used in the practice of acupuncture and the sanitation of acupuncture offices. This office uses only single-use disposable needles, and disposes of them in a manner consistent with OSHA and Colorado State regulations. We are trained in the recommendation and application of adjunctive therapies and herbs as defined by traditional Oriental medicine concepts

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I have read and understand the above disclosure statement. I understand my rights and responsibilities as a patient.

Patient's Name (Print): _____

Signature of patient or legal guardian

Date Signed

Kim LeBrun, L.Ac. 303-577-9977
Integrative Health, Inc 5191 S. Yosemite, Suite B Greenwood Village, CO 80111

Terrell Kennet, LAc
PROVIDER NOTICE OF PRIVACY PRACTICES

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY. TERRELL KENNET, L.AC. AND ALL OTHER HEALTHCARE PROVIDERS ARE REQUIRED TO INFORM YOU, THE PATIENT, HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. THE FOLLOWING ALSO OUTLINES HOW YOU CAN ACCESS YOUR HEALTH CARE INFORMATION.

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We may use your health care information without your authorization for the following reasons:

6. Public health safety
7. Auditing purposes
8. Emergencies
9. At the request of your insurance carrier
10. When required by law

In all other circumstances, we will ask your written permission to release your medical information in the form of a "Release of Medical Records" form. If you choose to sign such a form, you have the right to revoke that authorization at any time.

If at any time we change our policies in regard to your medical information, you will be informed with a new "Notice of Privacy Practices" form and will be asked to sign it.

You have the right to view and obtain a copy of your medical record. You also have the right to know to whom we have disclosed your medical records. If you believe the information in your medical record is not correct or missing information, you have the right to request that such information is corrected or added to your medical record.

If you have any questions or concerns about your medical records, please contact Integrative Health, Inc. at 303-577-9977, or you can file a written complaint with the U.S. Department of Health and Human Services. Integrative Health, Inc. is required by law to protect your medical information and to provide this notice to you, along with your signature acknowledging your receipt of this information.

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I authorize Integrative Health, Inc. to release any information required to process this claim to any insurance company or attorney in this case. I also authorized any insurance company or medical provider to release my medical records to Integrative Health, Inc. This information is to be used for the purpose of processing my claim for benefits due. I hereby agree that a photocopy of the document is as valid and effective as the original copy.

PAYMENT AGREEMENT

I hereby authorize my insurance benefits to be paid directly to Terrell Kennet, L.Ac. I assume full responsibility for and agree to pay all costs, charges, and expenses of every kind and description for services furnished by Terrell Kennet, L.Ac. I must pay charges and services not covered by any insurance or other third-party payer and/or not paid to Terrell Kennet, L.Ac. for any reason within a time period Terrell Kennet, L.Ac. deems reasonable. The amount of the bill shall be due and payable upon presentation to the patient, his/her agent, guardian, conservator or third-party responsible for payment of the charges.

CANCELLATION NOTICE

Kindly give 24 HOURS NOTICE for cancellations. Late cancellations are subject to 50% CANCELLATION FEE, no shows or cancellation with less than 2 hours before scheduled appointment are subject to a 100% CANCELLATION FEE. Cancellation fee is based on the cash rate of service. Call-backs or email reminders are a courtesy and I understand that I am responsible for my appointment and providing 24 hour notice for cancellations or reschedules.

Patient's Name (Print): _____

Signature: _____ Date Signed: _____

Terrell Kennet, LAc
Colorado Mandatory Disclosure and Consent Form for Acupuncture

Acupuncture has been explained to me as a treatment consisting of the insertion of needles through the skin at specific points on the surface of the body, by well-trained, licensed acupuncturists. Acupressure, acupuncture, moxabustion, cupping, allergy elimination technique, nutritional or herbal counseling are considered experimental procedures and are not considered a substitute for Western Medicine. Therapies and advice offered shall not be construed by the client to be a diagnosis or treatment of any disease or injury.

I understand that complications may result from acupuncture treatment. Among these possible complications are areas of anesthesia, fainting, weakness, nausea, hematoma, infection, pain and discomfort, pneumothorax, and aggravation of present symptoms. Being hungry, tired, or stressed can infrequently make the body more sensitive to the acupuncture treatment. Please tell your provider if you have any conditions that may inhibit blood clotting, such as hemophilia, or coumadin use. Please use caution walking with bare feet in the treatment room. I, the patient, further understand and agree to hold harmless, indemnify and protect against court action the individual acupuncturist/therapist as well as the management and owners of this clinic, in the event of accidental injury on these premises.

We gladly accept auto claims, workman's comp, and insurance as payment. Insurance coverage depends on your plan. Please call head of time to find out what your acupuncture benefits are.

Colorado law requires all acupuncturists provide the following information to clients on their first visit:

Education, Experience, Degrees, Certificates, Credentials, Licenses, Certificates, and Registrations:

Terrell Kennet, LAc has been licensed by the state of Colorado, which requires that she graduate from an approved institution (a four year program), and pass the National Board Exam (NCCAOM) for acupuncture and oriental medicine. Terrell Kennet, LAc. has never had any license, registration, or certification issued by any local, state or national healthcare agency, revoked or suspended.

Cash Fee Schedule:

Initial Acupuncture Treatment (incl. exam).....	\$120.00*
Follow-up Acupuncture Treatment.....	\$80.00*
5-visit Family Plan.....	\$375.00
10-visit Family Plan.....	\$700.00
20-visit Family Plan.....	\$1300.00

Insurance Fee Schedule:

Each insurance company is different.

*Coupons or other special discounts may apply. All fees are due on the date of service. Family plan refunds: total paid less \$80 per treatment received. There are no expiration dates on family plans. Any questions about billing should be discussed with your provider.

This office complies with all rules and regulations promulgated by the Colorado Department of Health related to the proper cleaning and sterilization of needles used in the practice of acupuncture and the sanitation of acupuncture offices. This office uses only single-use disposable needles, and disposes of them in a manner consistent with OSHA and Colorado State regulations. We are trained in the recommendation and application of adjunctive therapies and herbs as defined by traditional Oriental medicine concepts

Each patient who visits this office is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.

In a professional relationship sexual intimacy is never appropriate and should be reported to the Director of the Divisions of Registrations in the Department of Regulatory Agencies: The Colorado Department of Regulatory Agencies regulates the practice of acupuncture. Send inquiries to the attention of: Director of the Division of Registrations 1560 Broadway, Suite 1545 Denver, CO 80202. Phone: (303) 894-2464. Each patient may seek a second opinion from another healthcare professional or may terminate therapy at any time. If you have any questions about any part of your treatments, billing statements, etc., please ask the office manager and tell your provider.

I have read and understand the above disclosure statement. I understand my rights and responsibilities as a patient.

Patient's Name (Print): _____

Signature of patient or legal guardian

Date Signed

Terrell Kennet, L.Ac. 303-577-9977
Integrative Health, Inc 5191 S. Yosemite, Suite B Greenwood Village, CO 80111