TRINITY NATURAL MEDICINE & ACUPUNCTURE (TNMA)
6505 218TH ST SW, STE 15
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(425) 582-2081

CONSENT FOR CARE & FINANCIAL POLICY FORM

This consent form is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

Consent for Care:
I, with my signature, authorize **Trinity Natural Medicine & Acupuncture (TNMA)**, and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body, and the sale or dispensing of drugs, supplements, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

I, with my signature, consent to all acupuncture and naturopathic treatments, modalities, and therapies as deemed appropriate by the doctor, Dr. Mary T. Tseng, ND, LAc, that reside within the scope of practice as outlined by Washington State law and standards of practice in the Naturopathic and Acupuncture professions. These may include but is not limited to: fine needle acupuncture, fire cupping, electro-acupuncture, moxa, ear seeds/pellets, acupressure, soft tissue manipulation, manual therapy, trigger point therapy, myofascial techniques, naturopathic spinal and skeletal adjustments, craniosacral, visceral manipulation, and counseling in lifestyle, nutrition, exercise and stress management. I understand my rights to forgo and reject any treatment, modality, or therapy that I am uncomfortable with, and that my request must be made known explicitly either verbally or written to the doctor.

Consent for Release of Information and Assignment of Benefits:
I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I consent to assign all payments for services directly to this practice. I further consent to the use for any practice operational needs as identified in the Privacy Practice Notice.

Financial Policy:
We appreciate you choosing TNMA for your healthcare. We will adhere to the following financial policy in order to consistently deliver high quality care and services. The patient/responsible party assumes responsibility to ensure that the financial obligation is fulfilled for the health care services received.

- I understand that I am responsible for all co-payments, amounts applied to deductibles, and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulations.
- I understand that if I have an insurance co-payment, I am expected to make payment when **checking-in** for my appointment unless otherwise instructed by the doctor (Dr Mary Tseng) or TNMA staff member..
- I understand that my contract with my insurance entity may or may not cover some services. All insurance policies are not the same. They vary by employer group. **Consultants at TNMA are not responsible or able**

to know every policy available. It is my responsibility to verify applicable coverage prior to receiving the services. For example, not all health plans include screenings as a benefit. If I seek care outside of the contract terms, I am aware that I may be responsible for all charges that are incurred.

Trinity Natural Medicine & Acupuncture is a physician owned and operated facility.
Thank you for your understanding and cooperation with this policy. It is our privilege to provide your medical care.

I have read and understand the Consent for Care and Financial Policy stated above and agree to accept full responsibility as described above.

_____ _____
Patient/Responsible Party Name (printed) **Relationship to Patient** (if applicable)

_____ _____
Patient/Responsible Party Signature **Date**

_____
Patient name if different from Responsible Party (printed)