



Acupuncture Consent

I, the undersigned, authorize Gary Piscopo, ND, L.Ac., to perform the Chinese medical treatment know as Acupuncture. I understand that acupuncture involves the insertion of sterilized needles through the skin at specific points on the body. I also understand that the practice of acupuncture includes the use of techniques such as cupping, electro-acupuncture, moxibustion, and others outlined by the Washington State law for licensed acupuncturists. I understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

Like all medical procedures, I recognize that acupuncture has potential risks and potential benefits. These risks and benefits are as follows:

Potential Risks: Many of the risks are similar to any insertion of a needle into a body, as in drawing blood or receiving an injection. These include light headedness, minor bruises or bleeding, a bent or broken needle at the site of insertion, possible infection, fainting, nausea, or weakness. There can also be discomfort at the site of insertion of the acupuncture needle. Additional risks include aggravation of symptoms existing prior to the acupuncture treatment and potential burns from the moxibustion technique.

Potential Benefits: Relief and resolution of the health concern being treated. Reduction and control of pain without the side effects of pharmaceutical intervention (i.e. addiction, mood changes, negative organ effects, etc.). Inducement of a greater sense of well being and an enhanced energetic balance leading to the prevention of further health concerns.

I hereby release Gary Piscopo, ND, L.Ac., from all liability in connection with the acupuncture and oriental medicine treatments I receive. I understand that I am free to discontinue treatment at any time.

Signature of patient

Date

Written Waiver to Continue East Asian Medical Treatment

Washington State law required the Department of Health to develop the requirements for the written waiver for East Asian medicine practitioners to use when the practitioner sees a patient with a potentially serious disorder. (18.06.140 RCW)

I, _____, acknowledge I may have a potentially

serious disorder. Gary Piscopo, ND, LAc requested a consultation or recent diagnosis from a physician or physician's assistant, osteopathic physician or osteopathic physician's assistant, naturopath or ARNP on that potentially serious disorder. I acknowledge that failure to pursue treatment from my primary health care provider may involve risks such as:

I, nonetheless, refuse to authorize a consultation or to provide a recent diagnosis from such a primary health care provider and wish to continue with treatment.

An East Asian medicine practitioner's scope of practice includes the following techniques and services:

- Acupuncture, including the use of acupuncture needles or lancets to directly or indirectly stimulate acupuncture points and meridians;
- Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians;
- Moxibustion;
- Acupressure;
- Cupping;
- Dermal friction technique;
- Infra-red;
- Sonopuncture;
- Laserpuncture;
- Point injection therapy (aquapuncture); and
- Dietary advice and health education based on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements;
- Breathing, relaxation, and East Asian exercise techniques;
- Qi gong;
- East Asian massage and Tui na, which is a method of East Asian bodywork, characterized by the kneading, pressing, rolling, shaking, and stretching of the body and does not include spinal manipulation; and
- Superficial heat and cold therapies.

I understand the services and techniques the East Asian medicine practitioner is authorized to provide will not resolve my underlying potentially serious disorder(s).

Date

Signature of Patient



Dr. Gary Piscopo, N.D., L.Ac.

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COUNSELING INFORMED CONSENT AGREEMENT: INFORMATION AND POLICIES

Provision of the following information and written acknowledgment of its receipt are required by Washington state law. Please read it carefully. I welcome the opportunity to discuss any questions or concerns you may have regarding this agreement or my services.

Please be aware that, unless otherwise stated, when I am working with you as a counselor, our relationship will be defined by that role. This means that, generally, I will not be diagnosing or treating health conditions during our counseling visits as this would distract from the therapeutic work we have come together to do. If you desire medical treatment, a separate appointment to address those issues can be made if this is agreeable to both of us.

Counselors practicing counseling for a fee must be registered or certified with the Department of Licensing for protection of the public health and safety. Registration of an individual with the department does not include a recognition of any practice standards, nor necessarily implies the effectiveness of any treatment.

Your Rights As A Client In Counseling

As a client in counseling, you have certain rights that are important for you to know. There are also certain limitations to those rights of which you should be aware.

As a client of a counselor registered or certified by the State of Washington, you have privileged communications under state law. With the exception of the situations listed below, and those requirements outlined in state and federal law, you have the right to have information you share with me held in strict confidence; that information includes the fact that you are seeing me. The privilege is yours, not mine, and cannot be waived without your consent. I will always act to maximize your privacy even when you waive your right to confidentiality.

The following situations are exceptions to your right to confidentiality:

1. If I believe that you are likely to do harm to yourself or to another person, I am required by law to take steps to protect you and/or the other person.
2. If you reveal that you have committed or are contemplating the commission of a crime, I may report that to the appropriate authorities.
3. If I believe that you may be physically or sexually abusing or neglecting a minor child or vulnerable adult, or if you report information to me about the possible abuse or neglect of a child, I am required by law to report this to the appropriate state agencies (i.e. Children's Protective Services or Adult Protective Services).
4. If you are currently in litigation, or become involved in litigation during treatment or file a complaint against someone for malpractice, you may be asked to disclose information regarding your therapy as part of that

process. Although I will request your consent to release information, I can be legally obligated by subpoena or court order to turn over my records and testify. Nevertheless, please inform me as soon as you know that you are likely to be in such a legal situation, so that I can exercise due caution and thereby protect your privacy.

5. If you submit claims to your insurance company, they will likely require some information regarding your treatment with me. Most insurance companies only require basic information, often including a psychiatric diagnosis. You have the right to know the diagnosis that I use in any communication with your insurance company or other third party payor or agency. Should you attempt to use your health insurance to cover my services, there are a few things you should be aware of. Some insurance companies will partially or fully cover my services and some will not. If this is a concern for you, please check with your insurance company regarding your eligibility for benefits and with me regarding the policies and procedures I use concerning health insurance or other third party coverage. I need to be very clear that I cannot guarantee that your treatment will be covered. **Further, you are ultimately responsible for covering the full amount of my fees in the event that your insurance company does not cover all or part of my services.** As noted, if you want me to file insurance for you, your signature(s) below indicates your permission to release any and all information requested to your insurance company or its representative such as a managed care company. When such is released, I cannot control how the information is treated, nor will I be responsible for any injury or claim for damages arising from the release of records or information as required by the insurance company or managed care organization.

6. If you have been referred to me by another health care provider, it is my practice to follow up with the referring individual. This is done to insure that both parties of your therapeutic team are kept up-to-date about your health care and that the duplication of, or omission of services are avoided. It is also sometimes the case that a referral letter may be necessary within some insurance systems to request additional visits. A copy of the referral letter I send to the referring individual is available to you at your request. In some cases it will be useful to the therapy for me to discuss your situation with others such as your physician, former therapist, etc. In such cases, I will seek your written permission for this exchange of information.

7. If you are seeing me in couples or family therapy and you, your partner, or another family member should happen to see me in an adjunctive individual session, information shared with me in that meeting may be shared by me in joint or family sessions if I believe it to be in the best interest of the work we are doing together. When working with couples, I adopt a "no secrets" rule. That is, should I speak individually with either party (e.g., via telephone), I reserve the right to disclose any information to the other party if I believe such information is relevant to the therapy process.

8. If our therapeutic relationship involves more than one person (e.g. spouse, parent, partner, etc.), I will not release any information to a third party (court, attorney, etc.) without the signed permission of all parties involved in our therapeutic work together, except as required by law. Your signature on this disclosure statement represents agreement to this requirement. It is important when working as a couple that each person feels safe to speak openly and honestly, without fears that material revealed in therapy will be revealed in court and used in a negative fashion. A parental separation or divorce is a difficult situation for all involved. In order to provide a safe environment for couples work, it is important that you agree not to call me as witness or to attempt to subpoena records in the event you choose to pursue divorce. While a judge may overrule this agreement and issue a court order for information, your signature(s) below reflect your agreement not call me as a witness nor attempt to subpoena clinical records.

9. You always have the right to request a change in treatment or to refuse therapy. It is important that what we do together meets your needs. If you believe you are not being helped, please tell me so that we can work through the difficulty together. If we are unable to do so, I will assist you in finding another therapist upon your request.

Although you are free to terminate therapy at any time, it is my request that you discuss your decision and reasons for termination at the beginning of a regularly scheduled session. I consider it of therapeutic value to

you that we bring your therapy to closure in a way that ensures all counseling issues have been dealt with to the best of your and my ability. In any case, your decision to terminate therapy will be respected no matter what the circumstances.

Benefits and Risks of Therapy

One potential benefit of therapy is the ability to detect, challenge, and change those beliefs and attitudes that create, maintain, and worsen feelings such as depression, anxiety, panic, anger, frustration, etc. Therapy can also help individuals gain new understanding about their problems and learn new ways of coping and solving problems. With new skills, people often report a significant reduction in their feelings of distress, improved general functioning, and improved relationships.

As with any health care intervention, there are no guarantees, and there are potential risks. Risks may include experiencing uncomfortable levels of feelings like sadness, anxiety, anger, frustration, etc., and you may recall unpleasant aspects of their personal history. You also go through periods of feeling worse before feeling better.

Other Considerations

I occasionally consult with colleagues and/or other professionals regarding my work with clients to gain feedback and suggestions about therapeutic options and directions. My work with you may be discussed in formal or informal sessions with my colleagues or staff here, or with other professionals with whom I seek consultations for my growth and professional development. During these consultations, no unique identifying information about you will be used. All discussions of this type with other professionals are subject to the same provisions of confidentiality discussed above.

I want to be clear that I am not a psychotherapist nor do I do psychotherapy or psychotherapeutic testing or evaluation. For that reason, I do not have the expertise to testify or provide documentation in legal cases that require these types of assessments, such as child custody cases or testimonials to psychological stability.

My office number is (509) 886-9355. I check my messages at frequent intervals throughout the day. Please be aware that I generally do not do therapy or crisis management over the phone. If the situation or issue we are discussing becomes more complex than I feel is ethically responsible to handle by phone, I may ask you to make an appointment to address it. Any phone calls exceeding five (5) minutes will be billed at the same rate as my office fees unless we have made other arrangements.

If there is an emergency, please call my office number and tell the office manager that this is an emergency. If no one is available in the office, the clinic beeper number is always available on our answering machine. If you are unable to reach me and are urgently in need of help, call the Seattle Crisis Clinic at (206) 461-3222 or Chelan Douglas County 24 hour Crisis Line (509) 662-7105. They can assist you in managing your situation.

Appointments and Fees

Appointments are usually scheduled once per week or once every other week. The session lasts for fifty (50) minutes unless we arrange in advance to meet for a longer time. Longer sessions will incur an extra charge based upon the amount of time we schedule. The scheduled time for your session is set aside for you. Except in emergency situations, if you miss a session without canceling, or if you cancel with less than 24 hours notice, I will bill you in full for that time. Insurance or other third party payors will not compensate you under such circumstances. If you are late for a session, you will be seen for the remainder of your scheduled time and charged the full rate.

Please call my office for my current fee structure. This fee is standard regardless of the number of people attending the session. As indicated above, your insurance company may or may not cover my services. Payment must be made at the conclusion of each session unless we specifically agree on another payment schedule. I accept cash, check, and VISA/MasterCard. I cannot accept medical coupons or barter.

If we come to an agreement that I will do work related to your treatment that is outside of our scheduled counseling, I will bill you on an hourly basis for all the time I spend on your case, including travel time to another location, meeting other professionals regarding your case, writing reports, doing specialized research, etc. My fee for this type of work is \$95.00 per hour.

Training and Therapeutic Approach

My educational preparation in psychology and counseling includes a Doctorate in Naturopathic Medicine from Bastyr University in Seattle, WA and an externship in Family Counseling at Valley Counseling Associates in Renton, WA. Prior to this, I received my B.A. degree in psychology at the University of California, San Diego. I also worked in the field of psychiatric medicine as a mental health counselor for twelve years, which included participation in child, adolescent, and adult in-patient mental health programs. In my last position at Stevens Memorial Hospital in Edmonds, WA, our unit hosted the New Life Program, a Christian-based mental health care curriculum. In working closely with the staff of this program, I learned invaluable skills in the use of integrating spirituality with more conventional psychological approaches to counseling. My dual role as a doctor and counselor gives me an added scope of understanding in addressing the physical, mental, emotional, or spiritual concerns of my clients.

My therapeutic orientation is eclectic and derived from several fields of thought. A large part of my focus is on wellness-centered therapy. I also have a strong background in humanistic psychology, especially the Rogerian system. I have been exposed to several other orientations to counseling during my training, including Systems Family Therapy, Neurolinguistic Programming, Cognitive Therapy, Gestalt, and Narrative Therapy. As each individual I work with is unique, my treatment approaches for each client are tailored specifically to meet their needs and their process of growth. Being dedicated to the science of therapy as well as the art, I continue to educate myself in newer methods of therapeutic interventions through a review of the literature, workshops, and classes offered for in therapy for medical professionals.

Each course of treatment is a distinct creation of its participants and therefore your therapy will be a blend of what you and I do together. Part of my responsibility in your therapeutic process is to structure an environment that is both safe and supportive. I am also responsible for developing and implementing a course of treatment that will most effectively deal with your issues. You are responsible for your choices, your perceptions and the pace of reaching your therapeutic goals. While I cannot guarantee that specific changes will take place as a result of our counseling together, I am optimistic that change can occur.

In supporting your perception of reality, present and past, I will not attempt to determine in a legal sense whether the events you describe happened exactly as you remember them. I may, for the sake of therapeutic progression, challenge your views and remembrances, make suggestions, and give advice, but ultimately it is you who are in charge of what decisions you make concerning your life and how you implement them. For this reason, it will be your task to set the goals for the therapy session and to continue to work toward change outside of the therapy hour. My role is to listen, educate and support you during this period of change. You are embarking on a journey of inner exploration that is well worth taking. I look forward to traveling a part of its course with you.

I ascribe and adhere to the Code of Ethics of the Naturopathic Profession. I must also answer to the ethical and professional standards of the Uniform Disciplinary Act for the Regulation of Health Professionals.

