REGENERATIVE HOLISTIC WELLNESS

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Acupuncture, Herbal Medicine, Holistic Nutrition

CONSENT TO SERVICES

I have read and understand the information included in this form and acknowledge that the procedures, limitations, potential risks and benefits of service(s) have been explained to me. I have also received a copy of the Notice of Privacy Practices. I understand my health information will be used and disclosed consistent with this Notice, and that I have the right to request restrictions on certain uses and disclosures of my health information. Further, I have had the opportunity to ask my acupuncturist questions regarding the proposed services, this consent form and other pertinent information, and have received satisfactory explanations. I understand that I am free to discontinue service at any time.

By voluntarily signing this form, I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named above. 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.

[ ] Mr. [ ] Mrs. [ ] Ms. _____ (printed name)

Street Address: _____

City, State, Zip: _____

Date of Birth: _____ Email: _____

Phone: _____ [ ] work [ ] cell [ ] home

Alternate Phone: _____ [ ] work [ ] cell [ ] home

Signature of client (or parent or guardian if client is a minor or otherwise unable to sign this form):

_____ Date: _____

Services to Be Provided:

I understand that acupuncture serves individuals with a wide range of complaints including both acute and chronic healthcare issues. I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, application of heat to the skin, cupping and nutritional counseling.

Possible Risks and Side Effects:

While acupuncture, as practiced by professionally trained acupuncturists, is considered quite safe, I understand that risks and side effects may include, though are not limited to: bleeding, bruising, soreness, dizziness, fainting, shock, stuck or bent needles, numbness and tingling near the needling sites that may last a few days, temporary pain and discomfort, and temporary aggravation of symptoms

existing prior to treatment. Bruising is a common side effect of cupping. Burns and/or scarring are a potential risk of moxibustion and cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I do not expect my acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on my acupuncturist to exercise judgment during the course of treatment which she thinks at the time, based upon the facts then known, are in my best interest.

Infectious Disease Prevention:

I understand that infectious diseases are carried through the air, through physical contact, and through body fluids. I understand that my acupuncturist follows universally prescribed precautions and procedures (such as clean needle technique and hand washing) to prevent the spread of infectious disease.

No Guarantees:

I know that each person is unique and has ultimate responsibility for his or her own healthcare. I acknowledge that I have not received any guarantees or promises as to the results or success that will be obtained from the services provided.

Client Responsibilities:

I understand that it is my responsibility as a client to inform my acupuncturist of all aspects of my health and that, as service progresses, to inform my acupuncturist of changes that occur. I will inform my acupuncturist if I am pregnant and/or suspect pregnancy at any time. If I experience any pain, discomfort or possible adverse side effects, it is my responsibility to immediately notify my acupuncturist.

Medical Treatment:

I recognize that acupuncture services are not a substitute for a medical doctor and that my acupuncturist will not suggest that I discontinue medical treatment. I understand that if I am currently under a physician's care, I should continue as long as I and my physician deem necessary. It is my responsibility to consult with my physician before altering any medications or medical treatments. I understand that my acupuncturist may request a physical exam if it has been over a year since my last exam. I am free to consult a medical doctor or any other licensed practitioner at any time. I understand also that if there is an emergency or worsening of my health condition, or if a new ailment or condition arises, that I should consult a licensed physician.

Fees and Charges:

I have been informed of the fees for service, and I understand that payment is due when the services are provided. If I do not cancel an appointment at least 24 hours in advance, I understand that I am responsible for paying the full session fee. If I am late to my appointment, I am responsible for paying the full session fee regardless of the amount of time remaining after my arrival.

_____ date: _____