INFORMED CONSENT for TREATMENT

I (print full name) _____ hereby agree and consent to the performance of acupuncture and other Oriental Medicine procedures as described below. I understand that such procedures may include, but are not limited to acupuncture, moxibustion, cupping, gua-sha (dermal friction technique), infrared heat lamp, breathing techniques, auricular therapy, exercise therapy, Tuina (Chinese manual body work), Chinese or western herbal medicine, and nutritional counseling based on traditional Chinese medical theory. I accept that no guarantee is made concerning the results of my treatments, and I have been informed that I may stop treatment at any time.

Acupuncture is a technique utilizing fine stainless steel, sterile, disposable needles inserted at specific points in the body to correct various ailments.
Moxibustion is the application of indirect heat by burning a stick or cone of compressed Folium Artemisiae vulgaris (Mugwort), over acupuncture points.
TDP lamp is a device that emits infrared heat by passing an electric current through a plate impregnated with minerals. The minerals when electrically charged emit an infrared wavelength that penetrates deeply into the skin to improve circulation.
Cupping utilizes round suction cups over a large muscular area or joint to enhance blood circulation to the designated area. **Gua-sha** technique works in a similar way to improve circulation but instead of using suction cups, the therapy scraps the affected area with the edge of a rounded object such as a Chinese soup spoon.
Tui-na is a form of Chinese body treatment (massage) used in facilitating healing and pain management. Occasionally there may be increased soreness at the sites of treatment on the day of, or day following treatment.
Auricular therapy is the diagnosis and treatment of the body based on a theory of imaging the body to the ear. The ear contains hundreds of small acu-points that correspond to body systems. Small seeds from the Vaccaria plant are placed on a small band-aid or tape and applied to these acu-points. The seeds are then pressed routinely by the patients stimulating these acu-points to produce the desired effect.

I have been informed that the therapies stated above are safe methods of treatment, but may have side effects, including bruising, numbness, or tingling, dizziness or fainting, exacerbation of pre-existing condition, minor swelling, bleeding, hematoma may occur at the site of insertion and may last a few days. A sensation of lightheadedness may occur after treatment. I will immediately notify the physician if I experience any symptoms or problems. I understand that I should not make significant movements while the needles are being inserted, manipulated, retained, or removed.

RELEASE OF INFORMATION

I (initial) _____ consent to the use and disclosure of my protected health information for treatment, payment, and clinic operations. Also, I have given my written consent that my health information be shared with the people, their addresses and/or contact numbers on the "Intake/Referral" form. I understand that I have the right to revoke this consent, in writing, at any time. However, the revocation will not affect any disclosures made in reliance of my prior consent.

NOTICE of PRIVACY PRACTICES and PATIENT RIGHTS

I (initial) _____acknowledge that I have received a copy of the "Notice of Privacy Practices and Patient's Rights" and that I have had the opportunity to ask questions about it. All questions I have asked have been fully answered.
Please sign and date below pertaining to above: "Consent for Treatment", "Release of Information", and "Notice of Privacy Practices and Patient Rights".

_____

Patient's Signature Date Signed

_____

Guardian's Signature Date Signed

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