INFORMED CONSENT

Informed Consent

I understand that acupuncture involves the insertion of pre-sterilized, disposable needles through the skin at specific points and that additional therapies (such as herbal therapy, Asian nutrition therapy, acupressure, cupping, gua sha, and moxibustion therapy, electrical stimulation and TDP heat lamp) may be suggested to support the treatment process. All therapies will be fully explained before administration. Side effects such as local bruising, needle sickness, broken needles, pain at site of insertion, infection, pneumothorax, spontaneous miscarriage, burns from use of moxibustion, emotional release and allergic reaction (from some herbs) are rare but possible.

I understand that these methods are not an exact science, and that no results are guaranteed. I agree that these eastern modalities compliment western medicine, but do not replace the need for western medical treatment.

If I agree to take herbal medicine, I understand that I must follow all administration and dosage instructions. I understand that my practitioner is providing dietary guidance based on Asian medicine principles of nutrition and is not a licensed dietician. During the course of treatment, I agree to inform my practitioner of all health and medication changes, especially possible pregnancy. I agree to contact my practitioner immediately if I experience any problem which I associate with the treatments listed above and will go immediately to the hospital if I experience a medical emergency. I understand that acupuncturists practicing in Wisconsin are not primary care providers and that treatment alternatives may be available from a physician. I consent to receive the therapies listed above, understand the risks and understand that I may refuse any treatment at any time.

I understand that Balance Point does not diagnose illness or disease of either physical or mental disorders. I agree to check with my physician before starting any herbal and/or nutritional supplements. I understand my alternative healthcare provider must be aware of my existing medical condition and agree to take full responsibility in updating Balance Point in regards to any change in my medical condition.

I understand that acupuncture is conducted in a private or group setting at Balance Point Natural Medicine, LLC. I understand that my conversations in the group room may be overheard by others sitting nearby. I understand that if I need to have a private conversation with the practitioner, it is best to do so by telephone or by scheduling an appointment to talk privately.

I agree to pay in full at the time of each service. I agree to provide 24 hours notice for any cancellations, and understand fees may apply for late cancellations. I agree to pay any fees that may apply to returned checks and/or late cancellation.

I understand that Balance Point may record medical and other information concerning my treatment. I understand that balance Point abides by federal regulations regarding patient privacy as defined under 45 CFR 164.528. I know that I can ask for more information regarding this procedure (HIPPA regulations)or request a restricted release of information.

Patient Signature: _____ Date: _____

Patient Printed Name: _____

Witness Signature:_____ Date: _____

CONSENT TO TREAT A MINOR CHILD

I authorize Balance Point Natural Medicine, LLC to administer Acupuncture and Oriental Medicine as deemed necessary to _____ who is my _____ (relationship).

Adult Signature: _____ Date: _____

Witness Signature:_____ Date:_____