ACUPUNCTURE & WELLNESS CENTER

PATIENT & PRACTITIONER ADVISORY TO CONSULT PHYSICIAN

The Acupuncturists at Acupuncture & Wellness Center are committed to your health and well-being. While we believe that Traditional Chinese Medicine has a great deal to offer as a health care system, it cannot totally replace the resources available through biomedical physicians. Consequently, we recommend that you consult a physician regarding any condition(s) for which you are seeking acupuncture treatment.

I, the undersigned, do affirm that _____ (patient) has been advised by the Licensed Acupuncturist treating my condition at Acupuncture & Wellness Center to consult a physician regarding the condition(s) for which such patient seeks acupuncture treatment.

_____ _____

Patient or Representative Signature Date

_____ _____

Licensed Acupuncturist Date

While your private health information is always kept confidential there are times when particular health conditions, illnesses or injuries may require the practitioner to seek more information about additional treatments you are receiving. Please read the following and sign below.

I authorize the licensed acupuncturist to request, discuss and/or share information about my current treatment and progress with my medical doctor, massage therapist, chiropractor, physical therapist or other health care practitioner as listed on the intake form.

Signature: _____ Date: _____

INFORMED CONSENT TO ACUPUNCTURE TREATMENT

I hereby request and consent to performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or the patient named below, for whom I am legally responsible) by the acupuncturist named above and /or licensed acupuncturists who now or in the future treat me while employed by the working or associated with serving as back up for the acupuncturist named above, including those working at the clinic or office listed above or any other office or clinic, where signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxabustion, cupping, electrical stimulation, Tui-na (Oriental massage), and nutritional counseling.

I have been informed that acupuncture is generally a safe method of treatment, but that it may have side effects, including bruising, bleeding, numbness or tingling near the needle sites that may last a few days and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including pneumothorax. Infection is another possible risk, although the clinic uses sterile single use disposable needles and maintains a clean and safe environment. Burns and/or scarring are potential risk of moxabustion and cupping. I understand while this document describes major risks of treatment, other side effects and risks may occur.

I will notify the licensed acupuncturist or clinical staff if I am to become pregnant.

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

I understand that Acupuncture & Wellness Center offers complimentary insurance verification for acupuncture services. I also understand that it is ultimately my responsibility to know my own insurance benefits and that it is my responsibility to cover any costs that are incurred for acupuncture services including any deductibles, copays or co-insurance payments that need to be met. If for some reason my insurance company does not pay Acupuncture & Wellness Center for acupuncture services provided, it is my responsibility to pay any balance owed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my consent.

By voluntarily signing below, I show that I have read the above consent to treatment, have been told about the risks, and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present and any other future condition(s) for which I seek treatment.

_____	_____
Print Patient Name	Licensed Acupuncturist
_____	_____
Signature of Patient or Representative	Date of Consent