IMFORMED CONSENT TO ACUPUNCTURE TREATMENT

I hereby request and consent to the performance of Helena Lee L.Ac., and/or other licensed acupuncturist for treatments including acupuncture and/or other procedures. I have discussed the nature and purpose of my treatment with the acupuncturist.

I understand that Oriental Medicine treatments may include, but are not limited to, acupuncture, micropuncture, moxabustion, cupping, Tuina and other East Asian forms of massage, Gua Sha, traditional Chinese herbal medicine, Qigong, and lifestyle/dietary counseling. I understand that herbs may need to be prepared and the teas consumed according to instructions provided to me either orally or in written form.

I understand that acupuncture is generally a very safe method of treatment with few, but some possible side effects, including bruising, pain, numbness at the needle site, dizziness or fainting. Bruising is a common side effect of cupping and Gua Sha. Moxabustion and the use of heat therapies may in rare instances cause burning or scarring. Chinese herbs that are recommended are traditionally considered safe when practice by professional practitioner of Oriental Medicine. I will notify a staff member if I become or suspect that I am pregnant. I will also notify a staff member at Acupuncture Herb Center of Wayne what drugs (medicinal or recreation) and supplements I take and if there is any change in them. I do not expect the clinical staff to be able to anticipate and explain possible risks and complications and I understand result cannot be guaranteed. I understand that a traditional medicine assessment of my condition is not the same as conventional medical diagnosis.

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

By voluntarily signing below, I show that I have read, or have read to me, the above consent to treatment, have been told about the benefits and risks of the above procedures, and have had an opportunity to ask questions. 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.

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Patient Signature *Date*

OFFICE POLICIES

Many insurance policies do cover acupuncture care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for acupuncture care. We require that you, the patient, be personally responsible for the payment of your deductibles and any co-pays. We will do our best to verify your insurance coverage and will bill your insurance in a timely manner.

- ***24*** *HOURS ADVANCE NOTICE IS REQUESTED FOR CANCELLATIONS. PATIENTS WILL BE RESPONSIBLE FOR THE APPOINTMENT FEE FOR ANY MISSED APPOINTMENT OR NON-EMERGENCY LATE CANCELLATIONS.*

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Patient Signature *Date*