

Acupuncture and Wellness Center

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### **Things to know before you come for the Acupuncture Treatment:**

1. **Please refrain from wearing perfume or cologne to ALL treatments.** Many patients coming to the office have severe allergies to scents and chemical products, and even trace amounts of the scents can cause them to have serious health reactions. Please do not use perfumes, scented lotions, colognes, etc, before coming to your treatment for the safety and wellbeing of all patients.
2. **Please do not scrape your tongue** with tongue scrapers on the market. The acupuncturist needs to see the coating and color of your tongue as this indicates important information for the exam.
3. **Please eat something before your treatment.** Do not go all day without eating and do not eat a heavy meal or something very sweet, like a candy bar. You can eat fruit, a sandwich, vegetables, granola bar, yogurt, etc.
4. **Please bathe well before your treatment.** You will have needles inserted into your skin and your skin needs to be clean. If your skin is not clean, the acupuncturist will not be able to treat you. She will take rubbing alcohol on a cotton swab and swab your skin, and the cotton ball needs to come clean in order for her to treat you.
5. **If you prefer, you may wear shorts and a shirt for the treatment.** Distal points will be used and at times you may have chest, abdomen or back acupuncture points used. A towel drape will be provided to cover you if needed.
6. **Please use the restroom before your treatment.** You will be unable to get off the treatment table once the needles are inserted.
7. **During the treatment try to be relaxed.** Whatever you do to relax your mind, body and emotions is what you need to do while you are laying on the table 20-30 minutes for the acupuncture treatment. The acupuncturist will need it quiet so she can focus on the treatment. Soft music can be playing in the background if you want to listen to it during your treatment.
8. **After the treatment, try not to do heavy physical activity for 3-4 hours.** Light walking is okay. Rest and drink some water. It usually takes 24-48 hours for the energy to move through all the meridians after your treatment. During this time you might feel a little more lethargic or you might feel energized. Different bodies react differently.
9. **Information book.** There is a book in the waiting room called *The Acupuncture Answer Book*. It is helpful if you read it as it answers a lot of questions. Please check the book out with the receptionist if you wish to borrow it until your next treatment. Relax and enjoy your treatment!

# Acupuncture and Wellness Center

## Notice of Privacy Practices Effective 05/04/09

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. If you have any questions about this notice, please contact Acupuncture and Wellness Center.

### **Who will follow this notice**

This notice describes the personal health information (hereafter referred to as PHI) privacy practices followed by our employees, staff and other personnel.

### **Your health information**

This notice applies to the information and records we have about your health, health status, mental health care, mental health status, alcohol and other drug treatment, and services you receive from our employees.

### **How we may use and disclose health information about you**

**For treatment.** We may use PHI about you to provide you with treatment or services. A staff member may obtain PHI about you and create a record of this information, which may then be used to determine the course of treatment that should work best for you. A staff member may call you to remind you of an appointment.

**For payment.** We may use and disclose PHI about you so that the treatment and service you receive at this office may be billed and payment collected from you.

**For health care operations.** We may use and disclose PHI about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your PHI to evaluate the performance of our staff in caring for you. We may also use PHI about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

### **Other uses and disclosure of health information**

We may use or disclose PHI about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

**To avert a serious threat to health or safety.** We may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

**Required by law.** We will disclose PHI about you when required to do so by federal, state, or local law.

**Public health risks.** We may disclose PHI about you for public health reasons to report suspected abuse or neglect of minors.

**Information not personally identifiable.** We may use or disclose PHI about you in a way that does not personally identify you or reveal who you are.

**Family and friends.** We may disclose PHI about you to your family members or friends if we obtain your written agreement to do so, or if we infer from the circumstances that you would not object. For example, we may assume you agree to our disclosure of your PHI to your spouse when you bring your spouse with you into a treatment room while the treatment is discussed.

**For workers' compensation.** We may share your PHI with workers' compensation agencies if needed for a benefit determination.

### **Other uses and disclosures of health information**

We will not use or disclose your PHI for any purposes other than those identified in the previous sections without your specific, written authorization. You may revoke that authorization in writing at any time, but we cannot take back any uses or disclosures already made with your permission.

### **Your rights regarding health information about you**

**Right to inspect and copy.** You have the right to inspect and copy your PHI, such as treatment records. You must submit a written request to Acupuncture and Wellness Center in order to inspect and/or copy your PHI. If you request a copy, we will charge a fee for the costs of copying, mailing, or other associated supplies.

**Right to amend.** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, submit a letter stating what information in your medical record you would like amended to Acupuncture and Wellness Center. We may **deny** your request for an amendment if it is

not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- a) we did not create
- b) is not part of the PHI that we keep
- c) you would not be permitted to inspect and copy
- d) is accurate and complete

**Right to an accounting of disclosure.** You have the right to request an “accounting of disclosure,” a list of the disclosures we made of medical information about you for purposes other than treatment, payment, and health care operations. Submit this request to Acupuncture and Wellness Center. It must state a time period not longer than six years and may not include dates before Jan 15, 2008. Your request should indicate in what form you want the list (e.g. on paper, electronically). We will charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Right to request confidential communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location (e.g. at work or by mail). To request confidential communication, submit a letter stating your request to restrict the use/disclosure of medical/mental health information and/or confidential information to Acupuncture and Wellness Center. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**You have the right to a paper copy of this notice.** You may ask for a copy of this at any time.

**Changes to notice.**

We are required to abide by the terms of this notice. However, we reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

**Complaints**

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Director at Acupuncture and Wellness Center, 6049 E State Blvd, Fort Wayne, IN 46805.

**Office Policies**

**Financial Policy**

Fees for all services and products are due at the time of service. Payment may be made in the form of cash or check.

**Note: There is a \$40.00 returned check fee for non-sufficient funds.**

**Appointments**

As a courtesy to other patients, please be on time for your scheduled appointment. Should you need to cancel or reschedule, please give 24 hour notice to avoid a \$40.00 cancellation fee.

**Disclosure of Patient Information**

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your syndrome differentiation (including treatment, payment, and health care operations).

Name and Phone Number \_\_\_\_\_  
Name and Phone Number \_\_\_\_\_  
Name and Phone Number \_\_\_\_\_

My signature below indicates that I have reviewed or had read to me the Office Policies and Notice of Privacy Practices which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Note: I fully understand that a cell phone is not a secure and private line.

Note: I will notify Acupuncture and Wellness Center if I am or become pregnant while receiving treatments.

\_\_\_\_\_  
Signature of Patient or Legal Representative Date

If signed by legal representative, relationship to patient \_\_\_\_\_

I give my consent to receive e-mails, mailings and information from Acupuncture and Wellness Center. **Initial** \_\_\_\_

## INTAKE FORM

Name \_\_\_\_\_ Today's date \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Gender  Male  Female  
Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ e-mail \_\_\_\_\_  
Place of birth \_\_\_\_\_ Date of birth \_\_\_\_\_  
Relationship status:  single  married  separated  divorced  widowed  
 living with partner  other \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Family physician \_\_\_\_\_ Phone number \_\_\_\_\_  
In an emergency notify \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Emergency phone number (day) \_\_\_\_\_ (evening) \_\_\_\_\_  
Referred by \_\_\_\_\_  
Have you been treated by Acupuncture or Oriental Medicine before?  No  Yes - when?

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### Consent for Acupuncture

I, the undersigned, understand acupuncture treatment to involve the use of needles, TDP heat therapy, cupping, gua sha, plumb blossom, acupressure, moxibustion, and electrical stimulation, etc. The risks, although limited, include: puncturing organs in the abdomen or chest cavities. Acupuncture may affect people on all levels: physical, emotional, mental, and spiritual, because it works with the whole body to create balance. The duration of treatment varies from person to person depending on the specific illness and their constitution. I fully understand that there is no stated or implied guarantee of success or effectiveness after a specific treatment or a series of treatments.

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**Patient's signature** (*Parent or Guardian if Patient under 18*) \_\_\_\_\_

**Date** \_\_\_\_\_

What is your main complaint today? \_\_\_\_\_

How long ago did this problem begin? \_\_\_\_\_

Have you been given a diagnosis for this problem? If so, what \_\_\_\_\_

What kinds of treatment have you tried? What were the results? \_\_\_\_\_

Are you currently receiving treatment for your problems?  No  Yes \_\_\_\_\_

Does anything improve your problem? \_\_\_\_\_

What seems to make this condition worse? \_\_\_\_\_

Is this a job related accident?  No  Yes If yes, date of injury \_\_\_\_\_

Is your visit due to injuries sustained in a motor vehicle accident?  No  Yes - date of injury \_\_\_\_\_

### Family Medical History (check if any of the following applies to any family members)

- |                                     |  |  |  |   |
|-------------------------------------|--|--|--|---|
| <input type="checkbox"/> alcoholism | <input type="checkbox"/> cancer        | <input type="checkbox"/> hepatitis           | <input type="checkbox"/> pulmonary disease | <input type="checkbox"/> thyroid disease  |
| <input type="checkbox"/> allergies  | <input type="checkbox"/> diabetes      | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> seizures          | <input type="checkbox"/> venereal disease |
| <input type="checkbox"/> asthma     | <input type="checkbox"/> heart disease | <input type="checkbox"/> pacemaker           | <input type="checkbox"/> stroke            | <input type="checkbox"/> other _____      |

# of Children and ages: \_\_\_\_\_

### General health

Mother's Side \_\_\_\_\_

Father's Side \_\_\_\_\_

Siblings \_\_\_\_\_

If any of the above is deceased, what was the cause? \_\_\_\_\_

**Your Past Medical History** (Please check if you have now, or had in the past.)

- |   |                                      |  |  |   |
|---|--------------------------------------|--|--|---|
| <input type="checkbox"/> AIDS/HIV         | <input type="checkbox"/> chicken pox | <input type="checkbox"/> heart disease       | <input type="checkbox"/> pacemaker       | <input type="checkbox"/> thyroid disease  |
| <input type="checkbox"/> alcoholism       | <input type="checkbox"/> diabetes    | <input type="checkbox"/> hepatitis           | <input type="checkbox"/> pneumonia       | <input type="checkbox"/> tuberculosis     |
| <input type="checkbox"/> allergies        | <input type="checkbox"/> emphysema   | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> polio           | <input type="checkbox"/> ulcers           |
| <input type="checkbox"/> arteriosclerosis | <input type="checkbox"/> epilepsy    | <input type="checkbox"/> measles             | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> venereal disease |
| <input type="checkbox"/> asthma           | <input type="checkbox"/> goiter      | <input type="checkbox"/> multiple sclerosis  | <input type="checkbox"/> seizures        |   |
| <input type="checkbox"/> cancer           | <input type="checkbox"/> gout        | <input type="checkbox"/> mumps               | <input type="checkbox"/> stroke          |   |

**Personal History**

Birth history (prolonged labor, forceps delivery, etc) \_\_\_\_\_

Childhood health \_\_\_\_\_

Location of upbringing (geographically prone to certain diseases, habits etc.) \_\_\_\_\_

Current emotional health \_\_\_\_\_

Current quality of life \_\_\_\_\_

Current relationship/quality \_\_\_\_\_

Current predominant emotion \_\_\_\_\_

Have you had any unusual stresses recently? \_\_\_\_\_

Favorite time of year \_\_\_\_\_ worst time of year \_\_\_\_\_

Hobbies and recreational habits \_\_\_\_\_

Do you have a regular exercise program?  No  Yes – explain \_\_\_\_\_

Have you traveled abroad in the past year?  No  Yes – Where? \_\_\_\_\_

If applicable, please describe smoking or alcohol intake: \_\_\_\_\_

If former use, number of years quit: \_\_\_\_\_

Surgeries (type and date): \_\_\_\_\_

Significant trauma (auto accidents, falls, etc): \_\_\_\_\_

Significant dental work (type and date): \_\_\_\_\_

Occupational stress (chemical, physical, psychological, etc): \_\_\_\_\_

Have you ever been treated for emotional problems?  No  Yes – \_\_\_\_\_

Have you ever considered or attempted suicide?  No  Yes – \_\_\_\_\_

Any neurological or psychological problems?  No  Yes – \_\_\_\_\_

Any nervous habits? \_\_\_\_\_

At present, receiving counseling for: \_\_\_\_\_

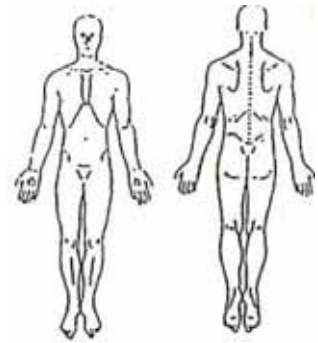
Medicines (prescription and over-the-counter drugs, vitamins, herbs, etc, taken within the last three months) \_\_\_\_\_

Are there any internal organ or systemic dysfunctions we should be aware of? \_\_\_\_\_

Are there any other health concerns that you would like to discuss? \_\_\_\_\_

Please circle on the diagram any areas of any type of pain or injury.  
 Please try to describe the type and quality of the pain. \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



For the following, please circle if you have experienced in the last three months.

**Vitality and immune system**

frequent colds	tender/achy all over	lethargic
frequent flu	chronic mental cloudiness	not easily adaptable
slow wound healing	low energy	other _____

**General**

fevers	poor sleep/insomnia	bleeding/bruising easily
chills	dream disturbed sleep	headaches: when _____
bodily heaviness	weight loss	where _____
poor/heavy appetite	weight gain	sudden energy drops?
day sweating	peculiar tastes/smells	time of day _____
night sweating	no desire to drink	other _____

**Cardiovascular**

high blood pressure	chest pain	rapid heart rate
low blood pressure	difficulty in breathing	fainting
blood clots	swelling of hands	dizziness
palpitations	swelling of feet	cold sweats
cold hands/feet		

**Head, eyes, ears, nose, & throat**

glasses	ear ringing	lump in throat
eye pain	earaches	thyroid problem
red eyes	hearing loss	jaw/teeth pain
night blindness	ear discharge	teeth removed
spots in vision	sore throat	many cavities
itchy eyes	throat tickle	facial pain
glaucoma	throat drainage	facial numbness
cataracts	teeth grinding	sinus congestion
eye dryness	TMJ	sinus drainage
eye discharge	mouth sores	sinus problem
excess tearing	excess saliva	other _____
nosebleeds	lip sores	
nasal drainage		

**Gastrointestinal**

nausea	ulcers	use antacids
vomiting	hernia	use fiber
abdominal pain	parasites	use digestive enzymes
digestive disorders	hemorrhoids	dark colored stools
belching	constipation	light colored stools
bad breath	diarrhea	BM 1 X day
gas	rectal pain/itching	BM greater 1 X day
indigestion	use laxatives	BM less 1 X day

**Genito-urinary**

Pain on urination	blood in urine	decreased libido (men)
Pain after urination	bed wetting	sexually trans. disease
Frequent urination	kidney stones	premature ejaculation
Unable to hold urine	frequent UTI's	pain or swelling of testicles
Decrease in urine	genital sores	erectile dysfunction
Waking up to urinate	impotency/infertility	cold or numb feeling in genitalia
How often? _____	inc. libido (men)	itching of genitalia

**Musculoskeletal**

muscle cramps	intermittent pain	knee pain
muscle weakness	arthritis	hip pain
general aches	recent sprains	other pain _____
spasms	back pain (where)	bone problems
acute pain	_____	muscular atrophy
chronic pain	wrist/hand pain	limited range of motion

**Neuropsychological**

seizures	fainting	unresolved grief
tremors	poor memory	substance abuse
concussion	easily angered	loss of balance
anxiety	depression	easily frustrated
areas of numbness	mania	substance abuse
lack of coordination	easily stressed	

**Respiratory**

acute or chronic cough	can't sleep lying down	easily winded with exertion
wet or dry cough	coughing blood	easily winded when lying down
phlegm produces (what color) _____	shortness of breath	shallow breathing
thick or thin phlegm	pain with deep breaths	asthma

**Skin and Hair**

acne	psoriasis	hair breakage
hives	dandruff	ulcerations
rashes	premature graying	fungal infections
eczema	hair loss	skin changes

**Pregnancy and Gynecology**

age of 1 <sup>st</sup> menses _____	lumpectomy	peri-menopausal
period between menses	# of pregnancies ____	bone density changes
duration of menses _____	# of births ____	birth control
pain before flow	# of miscarriages ____	what type _____
pain during flow	# of abortions ____	how long _____
pain after flow	hysterectomy	reg. self breast exams
__# of days bleeding	difficult births	fertility problems
__ heavy __ light bleeding	painful periods	vaginal itching
irregular periods	clots	vaginal discharge
cycle absent	spotting between menses	vaginal pain
breast lumps	decreased libido	vaginal sores
fibrocystic breasts	using HRT	vaginal odor
date of last pap _____		
date of last mammogram _____		

Patient Name:

Date:

### ARBITRATION AGREEMENT

**Article 1: Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

**Article 2: All Claims Must Be Arbitrated:** It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present, or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider an/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

**Article 3: Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

**Article 4: General Provision:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

**Article 5: Revocation:** This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between parties.

**Article 6: Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. \_\_\_\_\_ Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

\_\_\_\_\_  
PATIENT SIGNATURE (Or Patient Representative with relationship indicated)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
OFFICE SIGNATURE

Acupuncture and Wellness Center

\_\_\_\_\_  
DATE

## ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures with 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 below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or 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, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few day, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

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

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 written consent.

By voluntarily signing below that I have read, or have had read to me, 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 question. I intend this consent form to cover the entire course of treatment for my present condition and of any future conditions for which I seek treatment.

\_\_\_\_\_  
PATIENT SIGNATURE (Or Patient Representative with relationship indicated)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
OFFICE SIGNATURE

\_\_\_\_\_  
DATE

Rev 05/23/10