INFORMED CONSENT TO CARE AND TREATMENT

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various physical modalities, on me (or on the patient named below, for whom I am legally responsible) by licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up in this office.

I understand that methods of treatment may include, but are not limited to, acupuncture, cupping, laser, NAET, NET, TBM, presstaks, pressballs, homeopathy, herbal medicine and nutritional counseling. I have had the opportunity to discuss with the treating physician or other clinic personnel the nature and purpose of acupuncture treatments and other procedures.

I have been informed that acupuncture is a generally safe method of treatment, but as with all medical procedures, it may have some side effects, including bruising, 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 lung puncture (pneumothorax). Infection is another possible risk, although this office 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 Oriental medicine, although some may be toxic in large doses. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of herbs or nutritional supplements. I understand that some herbs or supplements may be inappropriate during pregnancy. 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 risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of the treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interests. I understand that results are not guaranteed.

I have read, or have had read to me, the above consent to treatment. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above- named procedures. 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.

PATIENT SIGNATURE: X_____

(or Patient's Representative) (Indicate relationship if signing for patient)

DATE: _____

Healing Roots Acupuncture
60 Austin Street, Suite 302 • Newtonville, MA 02460
(617) 549-5648 • www.HealingRootsAcupuncture.net

Patient Authorization for Appointment Reminders
Scheduling-Related Matters, Related Health Services
and/or Related Health Products

It is our desire for our staff to use your name, address, e-mail address and /or telephone number for the purpose of contacting you to remind you about scheduled appointments or other appointment-related issues. We would also like to advise you about health-related meetings, workshop, and products.

The use of this information is intended to make your experience with our office more efficient, and productive. We want to enhance your access to quality health care. If you choose not to authorize this information use, your decision will have no effect on your care from us or your relationship with our staff.

Mailing Address

City State Zip

E-Mail Address

Please indicate which number to use for:	Reminders	Messages	Don't Call
Home Telephone: _____	❑	❑	❑
Work Telephone: _____	❑	❑	❑
Cell Telephone: _____	❑	❑	❑
E-Mail Address: _____	❑	❑	❑

Would you like to be on our mailing list? Y N

Would you like to receive email newsletters? Y N

Your signature indicates your authorization of this activity.

Name (Printed) Signature Date

You may revoke this authorization at any time. Please advise us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

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