AcuHealing Center

Patient Information and Consent Form

Please read this information carefully, and ask your practitioner if there is anything that you do not understand. While acupuncture and other treatments (moxibustion, electroacpuncture, cupping, magnets, GuaSha) have proven to be highly effective in relieving pain, correcting conditions and maintaining overall wellbeing, practitioners are required to advise patients that there may be some risks. Although practitioners cannot anticipate all possible risks and complications that may arise with each individual case, you should be aware that the following side effects can occur. If any of these events occurs, please discuss them with your practitioner.

What are the possible side effects of acupuncture?

- In less than 3% of patients, symptoms may become worse before they improve for 1-2 days following treatment. This is usually a good sign. Please advise your acupuncturist if worsening of symptoms continues for more than 2 days.
- Fainting can occur in certain patients, but is very rare.
- Drowsiness can occur in a small number of patients; if this occurs, you are advised not to drive.
- Minor bleeding or bruising can occur from acupuncture or other techniques.

Is there anything your practitioner needs to know?

Apart from the usual medical details, it is important that you let your practitioner know:

- If you have ever experienced a seizure or fainting;
- If you have a pacemaker or any other electrical implanted devices;
- If you are pregnant;
- If you have a bleeding disorder;
- If you are taking anti-coagulants (blood thinners) or any other medication;
- If you have damaged heart valves or have any other particular risk of infection.

Statement of Consent

I confirm that I have read and understood the above information, and that I consent to having treatments and procedures in this office. I have read the possible risks of treatment above, but do not expect my practitioner to be able to anticipate and explain all possible risks and complications of my treatment. I also understand that I can refuse treatment at any time. I rely upon my practitioner to exercise judgment during the course of treatment, which, based upon known facts, is in my best interest I understand the practitioner may review my medical 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 I show that I have read this consent to treatment, have been told about the risks and benefits of treatments provided by this office, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment in this office.

Privacy Policy

The information received and collected about our patients during their visits to AcuHealing Center is strictly private and confidential. AcuHealing Center will not give, share, sell or transfer any

personal information to a third party unless required by law, or requested by the patient. Under absolutely no circumstances would this communication happen without the signed consent of the patient.

Appointment Policy

Welcome to AcuHealing Center! We are delighted to have you as a patient and look forward to providing you with the highest quality care. In order to optimize your relationship with us, please take a minute to read our appointment policy. Many of our clients are pleased to find out that we are usually on time. This is because a treatment room has been reserved for you, whereas most medical offices overbook by appointing several patients at the same time. Occasionally, there is a problem with patients who are not used to staying on schedule themselves. With that in mind, if you are going to be more than 15 minutes late, please call to confirm availability. A 24-hour notice for cancelled or rescheduled appointments is necessary in order to avoid the $25.00 cancellation/no-show fee. This allows us time to schedule another patient that would also benefit from treatment. This appointment policy allows us to develop a mutual consideration and respect for our time and yours.

HIPPA Compliance

All of your personal and health information remains confidential at all time between this office and the patient signing below.

My signature confirms that I have read, understand and agree with all of the above information.

____________________________ or ____________________________, relationship

Print name in full (Print name of Representative if represented by another)

____________________________ or ____________________________, relationship

Signature (Signature of Representative if represented by another)