ACUHEALTH
INTEGRATIVE MEDICINE

Chisie G. Klinglesmith, AP, DOM

402 North Babcock Suite 101 Melbourne FL, 32935 **(Inside Health For Life Wellness Center)**

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures with in the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated above and/or other licensed acupuncturist who now or in the future treat me as a back up for the acupuncturist named above.

I understand that method of treatments may include, but are not limited to, Acupuncture, Cosmetic Acupuncture, Micro-needling, Nano-needling, Electrical stimulation, Tui-na, Chinese herbal medicine, Gua sha, Cupping, Moxibustion, Nutritional counseling, Acupuncture injection therapy.

I have been informed that acupuncture and acupuncture injection therapy is generally safe method of treatments, but it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and /or scarring are potential risks of moxibustion and 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 at all times.

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 plants, animals and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may have 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, I wish to rely on the clinical staff to exercise judgement during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, 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, I show that I have read or have read to me, the above consent of 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 condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE_____**DATE**_____

(Or Representative)

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Privacy Policy

In accordance with HIPAA (Health Insurance Portability and Accountability Act) Regulation. AcuHealth Integrative Medicine takes the right to your privacy seriously. Therefore, we do not disclose any personal, health, financial, or any other information about you, or the services we provide to you to any third parties without your request or permission. As healthcare practitioners and administrators, we are also responsible for staying up-to-date with HIPAA regulations and for properly training all staff members and new employees to insure that your personal health information is not compromised.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment or healthcare operations as described in our Noticed. You have the right to revoke this consent, in writing except if we have already made release in reliance on your prior consent.

Patient Signature:_____

Print Name:_____

Witness:_____

Date:_____