Acupuncture Consent Form

Please read this document carefully and completely. Initial wherever indicated.

This is an informed consent that explains the expectations and risks associated with Oriental Medicine.

Nature of Treatment:

Your treatment may include acupuncture, moxibustion, cupping, electric or magnetic stimulation, acupressure, Tui Na (chinese medical massage), Gua Sha (dermal friction), Infra-Red (heat lamps), Chinese herbs, therapeutic exercises and dietary counseling based on the fundamentals of Chinese Medicine.

Purpose of Treatment:

The purpose of the treatment is to resolve your complaint, i.e. the reason you are seeking treatment. Acupuncture is a health care service that is based on an Oriental system of medical theory. Diagnosis and treatment, based on these theories are used to promote health and treat organic or functional disorders. While Oriental medicine has a great deal to offer as a health care system, it cannot replace the care of a medical physician. It is recommended that you consult a physician regarding any conditions for which you are seeking acupuncture treatment(s). This is a recommendation ONLY. The State of NY does not require an MD script for Acupuncture.

Benefit of Treatment:

Acupuncture and Oriental Medicine procedures have been used effectively to treat a variety of diseases for hundreds of years. We cannot guarantee the outcome of any course of treatment.

Risks of Treatment:

While acupuncture, Chinese medicine, and other treatments provided by this office have proven to be highly effective in correcting conditions and maintaining overall health and well-being, practitioners are required to advise patients that there may be some risks. Although practitioners cannot anticipate all of the possible risks and complications that

may arise with each individual case, you should be aware that the following side effects can occur. If there are particular risks that apply to your case, your practitioner will discuss these with you.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects including bruising, minor bleeding, numbness or tingling at or near the needle site, which may last a few days.

I may also experience some muscle soreness and petechiae (due to cupping or gua sha), which may also last a few days.

Drowsiness may occur in a small number of patients, and if affected, you are advised not to drive.

In a small percentage of patients, nausea can occur and symptoms may become worse before they improve; this is usually a good sign. Please advise your acupuncturist if worsening symptoms continue for more than 2 days.

An unusual risk of acupuncture includes fainting, spontaneous miscarriage, nerve damage, and organ puncture. Infection is another possible risk, however since this office uses only sterilized, disposable needles while maintaining a clean and safe environment, this is unlikely. Burns and scarring are potential risks of using moxibustion.

I have been informed I may stop treatment at any time.
I have read and understand the above __________ Please Initial

What your Acupuncturist needs to know:

Apart from your medical history, it is important to tell your practitioner if you have ever had a fit, fainted or have experienced any odd sensations. Please let us know if you have a pacemaker or electrical implants. Let us know if you have a bleeding disorder, are taking anti-coagulants, any other medication, have a risk of infection, or have a damaged heart valve.

I will notify the acupuncturist, who is caring for me, if I become pregnant. I have read and understand the above __________ Please Initial

Statement of Consent

I confirm I have read and understood the above information, and I consent to having treatments and procedures from Lorraine Lavenita, L.Ac. I have read the possible risks of treatment outlined above, but do not expect the practitioner to be able to anticipate and explain all of the possible risks and complications of treatment. I wish to rely on the acupuncturist to exercise judgments during the course of treatment, and decide what she thinks is in my best interest, based upon the facts that are known at the time.

I understand the practitioner and administrative staff may review my medical records, but all of my records will be kept confidential and will not be released without my written consent.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential. Lorraine Lavenita L.Ac follows the HIPAA regulations.

By voluntarily signing below I show that I have read this consent form, 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 for my present condition and further conditions for which I seek treatment.

____________________________________ ____________________

Please print your full name Date

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Patient Signature

Financial Policy Statement

Insurance:

I understand that billing of my insurance is done as a convenience to me. I understand that Lorraine Lavenita, L.Ac has verified my insurance information, however verification of eligibility and/or benefit information is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the

member's eligibility, any claims received during the interim period and the terms of the member's certificate of coverage applicable on the date services were rendered.

I understand that I am ultimately responsible for any charges for services provided to me.

I am responsible for co-payments, co-insurances and deductibles I may have at the time of service. These will be collected accordingly each visit. Insurance companies deny claims for a variety of reasons. If this occurs, the unpaid balance on my account is due and payable immediately. I understand that Lorraine Lavenita, L.Ac will not become involved in dispute between me and my insurance company regarding uncovered charges, pre-existing conditions, coordination of benefits, eligibility issues or any other matter, which causes the claim to be denied.

I authorize the release of any medical or other information necessary to process my claims.

I have read and understand the above __________ Please Initial

Timeliness:

It is important to be on time for all appointments. I understand that late arrivals may result in a shortened time appointments. I understand that if I am late my remaining time may not be sufficient for a full treatment. I understand that Lorraine Lavenita, L.Ac will do her best to make accommodations, nevertheless, I am responsible for the full session fee.

Cancellation Policy

I agree to pay the full price of a session if I do not comply with notifying Lorraine Lavenita L. Ac., within 24 hours before my scheduled appointment time.

______________________________ ______________________

Signature of patient Date