**Informed Consent to Treat**

I hereby request and consent to the performance of acupuncture treatments and/or other procedures within the scope of acupuncture practice as stated in New York Title VIII Article 160 on me (or on the person named below, for whom I am legally responsible) by Cheryl Wong, N.D., L.Ac. 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 Cheryl Wong, including those working at High Peak Acupuncture or any other 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), herbal/nutriceutical therapies, and nutritional counseling. I understand that the suggestion of herbal therapies is not regarded as medicine, but as food by the state of New York and that the use of herbs in various locales across the US and China is regarded as medical treatment. I understand that New York does not restrict the sale of herbs. I understand that herbs may need to be prepared as teas according to written or oral instruction provided by my clinician, and are often unpleasant to smell or taste. I will immediately notify a clinician of any unanticipated or unpleasant responses after the consumption of herbal/nutriceutical therapies.

I have been informed that acupuncture is generally safe, but that it may have some side effects including bruising, numbness or tingling near the needle insertion, which can last for a few days, dizziness, and rarely, fainting. Bruising is a common side effect of cupping that can last for 2-7 days. Burns and/or scarring are a potential risk of moxibustion and cupping if performed incorrectly. Unusual risks of acupuncture if performed incorrectly are 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 to minimize this risk. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. Recommended herbs and nutriceuticals (which are from plant, animal and mineral sources) are safe in the practice of Chinese Medicine, though may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy and will notify my clinician if I am or become pregnant. Some possible side effects of taking herbs include nausea, flatulence, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

I do not expect my clinician to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on my clinician to exercise judgment during the course of treatment, based upon the facts then known is in my best interest, drawing from empirical data and available scientific data. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records, 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 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 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 Name (Please Print)

Patient (or Guardian) signature Date

The statements below reflect that I have received and read this clinic’s office policies.

\_\_\_\_\_\_I have been given information about the importance of establishing care with a primary care provider. My initials here indicate that I understand this clinic’s advocacy for integrated medical care.

\_\_\_\_\_\_ I have read and understand the office financial policies. I accept responsibility for the charges incurred by the patient and agree to pay all bills at the time of service unless other arrangements are made.

\_\_\_\_\_\_\_\_ I have received the Notice of Privacy Practice and I have been provided an opportunity to review it.

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Patient Name (Please Print)

Patient (or Guardian) signature Date