Healing With Grace

Acupuncture & Chinese Herbalism

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Acupuncture Consent to Treatment

I hereby request and consent to the performance of Acupuncture treatments and other Oriental Medicine procedures on me (or on the patient named below, for whom I am legally responsible) by the below named licensed Acupuncturist.

Grace J. Stojanov, L.Ac.

Name of Licensed Acupuncturist

I understand that methods or treatments may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui Na massage, Gua Sha, Chinese or Western herbal medicine, nutritional counseling and/or supplementation, and/or magnets.

_____ (***prospective patient's initials***) Acupuncture attempts to normalize physiological functions, to modify the perception of pain and to treat certain diseases of dysfunction of the body. I have been informed that Acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infection and scarring. There have been extremely rare instances of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping. I do not expect the Acupuncturist to be able to anticipate all risks and complications. I wish to rely on the Acupuncturist to exercise judgment during the course of the procedure which the Acupuncturist feels at the time, based on the facts then known, is in my best interests.

_____ (***prospective patient's initials***) 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 Chinese Medicine. I understand the same herbs may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. If I experience any gastrointestinal reactions to the herbs, I will inform the Acupuncturist immediately.

_____ (***prospective patient's initials***) Healing With Grace Acupuncture & Chinese Herbalism is a teaching clinic and also occasionally collects patient testimonials in the following forms: written words, photos, and videos. Periodically, interns will shadow licensed acupuncturists during their medical rounds. The patient will always be asked prior to participating in these teaching or testimonial engagements and ultimately has the right to refuse. This consent subsection is only applicable in those situations in which the patient agrees to allow the intern's presence or to appear in said mediums and serves as a photo/video release form.

_____ (***prospective patient's initials***) I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above-named procedures. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. I understand it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss any emergency situation and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records for the reasons listed above. I understand that I have the right to revoke this permission in writing at any time.

Financial Agreement: _____ (***prospective patient's initials***) I agree to pay the full charge for any missed or forgotten appointments without giving 24-hour prior notice of cancellation. I agree to pay all charges incurred for services rendered.

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's name Date of Birth

_____ _____

Patient's signature Date signed

To be completed by the patient's representative, if the patient is a minor, or physically/legally incapacitated.

_____ _____

Name of Patient Patient's Representative

_____ _____

Relationship of Authority of Patient Witness