**Florida Holistic Medicine**
**2142 NE 123rd Street**
**North Miami, FL 33181**
**(772) 206-0638**

# INFORMED CONSENT FOR ACUPUNCTURE AND ORIENTAL MEDICINE TREATMENT

I herby request and consent to the performance of acupuncture treatments and other Chinese medicine procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the licensed acupuncturist, BG Mancini AP and or other licensed acupuncturists who now or in the future treat me while employed by, working with or serving as back-up for the acupuncturist named above, including those working in the office or clinic listed above or any other office or clinic, whether signatories to this form or not. I understand that my signature on this form indicates that I have read the following, and understand that if I have any questions about this information, I should ask the practitioner.

1. **Nature of Treatment**: I understand that methods of treatment modalities may include, but not limited to acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na, acupressure, Chinese Herbs, energy work, allergy elimination, Nutrition Response Testing, crystal work and nutritional counseling. I understand that herbs or supplements may need to be prepared and consumed according to the instructions provided orally and in writing as an essential part of my treatment plan. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs. I understand that the treatments will be explained to me prior to treatment for my condition.

2**. Purpose of Treatment**: I understand that the purpose of the treatment is to resolve my condition, the reason that I am requesting treatment. The procedures used will attempt to remedy bodily dysfunction or diseases, to modify or prevent the perception of pain, and to make normal the body's physiological functions.

3. **Risks of Treatment**: I have been informed that acupuncture and Chinese medicine is generally a safe method of treatment. However, I understand that Acupuncture and Chinese Medicine procedures may have some side-effects, including mild discomfort during or after insertion, localized bruising or swelling, numbness or tingling near the needling site that may last a few days. Gastro-intestinal upset, gas, nausea, stomachache, dizziness, vomiting, diarrhea, headache, rashes, hives, and tingling of the tongue may occur with the use of Chinese herbs. Some herbs may be toxic in large quantities. There is also a possibility of temporary aggravation of symptoms that existed prior to treatment. Bruising and swelling are a common side effect of needling or cupping. Unusual risks of acupuncture include fainting, spontaneous miscarriage, nerve damage and organ puncture, including lung puncture. Infection is another risk, although the clinic uses sterile needles and maintain a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. Some herbs and acupuncture points are contra-indicated during pregnancy. Please notify your practitioner if you **are or might** be pregnant.

4**. Use of Disposable Needles**: I understand that to prevent any possibility of infection from acupuncture, all needles used are pre-sterilized, one time use, surgical stainless steel needles that are disposed of after usage as medical waste. Needles are never reused.

5. **Unforeseen risks and suggested alternatives**: I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, best upon the facts then known is my best interest. I understand that the results are not guaranteed and I understand that I may stop treatment at any time. The practitioner, upon assessment of need, and in the best interest of the patient, will suggest alternatives/additions to the treatment, such as physical therapy, mio-fascial release, healing energy, exercise , yoga, meditation, nutrition, and other modalities, to ensure that the patient is receiving the most effective care.

**Your signature indicates that you have read, understand and agree with the above information.**

**Signature of patient (or parent if minor) _____ Date _____**

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## PAYMENT & APPOINTMENT POLICIES

### PAYMENT POLICIES:

**If my insurance does not pay for the treatment services, I agree to pay for them myself. Also, I agree to pay co-payments, deductibles, and/or coinsurances for treatment services as required by my policy.**

### ASSIGNMENT OF BENEFITS

**I authorize the insurance company to make payment to the practitioner for my treatments and services.**
**I authorize release of information concerning my (or my child's) health care, advice and treatment provided only for the purpose of evaluating and administering claims for insurance benefits.**

### APPOINTMENT POLICIES:

Please be on time for appointments. Failure to cancel an appointment with less than 24 hours notice will result in a $75.00 charge. Please note that your insurance carrier is not responsible for this fee, you are. Your consideration is well appreciated.

**HIPPA PRIVACY ACT** ensures that all of your personal and health information remains confidential at all times between this office, the billing company, your insurance company and you only. I understand that 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. Should you have any questions about the privacy of your information at this office, you may ask the practitioner at any time.

By voluntarily signing below, I show that that I have read, or have had read to me, the above consent to treatment, have been told above risks and benefits of acupuncture and other procedures, and have an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition or for any future conditions for which I seek treatment

**DISCLOSURE AUTHORIZATION**: I hereby voluntarily authorize the disclosure of information from my health records. The information is to be disclosed by Florida Holistic Medicinev and provided to this office, the billing companies for insurance and credit cards, and my insurance company.

**Your signature indicates that you have read, understand and agree with the above information.**

Signature of patient (or parent if minor) _____ Date _____