SERENITY
HOLISTIC HEALTH

INFORMED CONSENT

I herby request and consent to the performance of acupuncture treatments and other 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 acupuncturist named below 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 the acupuncturist named below, including those working at the clinic or office listed below or any other office or 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 (Oriental massage), Oriental herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that 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. Bruising is a common side effect of 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. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect and risks may occur. 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 Oriental Medicine, although some may be 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, 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, 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 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.

The clinical data gathered in practice, without names, may be used for statistical data and research. We are HIPPA compliant to protect your privacy. According to federal policy, we need your written consent for the following:

Do we have permission to make appointment confirmation calls? Yes No
If yes, what number(s) should we call?

_____(home, work, cell) Are we allowed to leave a message? Yes No

PATIENT SIGNATURE _____ **Date**_____
(Or Patient Representative)
Indicate relationship if signing for patient _____

OFFICE SIGNATURE _____**Date**_____
Serenity Holistic Health, LLC

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Cancellation Policy

Failure to attend appointments creates considerable delay in the provision of care for yourself, and blocks access to care for other patients in need.

In order to encourage appropriate use of our service and to promote accessibility, kindly observe our 24-hour cancellation policy. **If you cancel an appointment within 24 hours of the scheduled appointment time, or if you miss an appointment, you will be subject to a charge up to the value of your appointment.** If the appointment was reserved with a gift certificate the certificate will be forfeited.

I acknowledge and agree to the cancellation policy.

PATIENT SIGNATURE _____ **Date**_____
(Or Patient Representative)
Indicate relationship if signing for patient _____

OFFICE SIGNATURE _____ **Date**_____
Serenity Holistic Health, LLC