Salem Community ACUPUNCTURE

Consent for Treatment Form

Patient Information

Name _____ Date _____

Voluntary Consent

I hereby voluntarily request and consent to be treated, or give permission for my child/ward to be treated, with acupuncture; acupressure and other techniques based on Traditional Asian Medicine. I understand I may be given recommendations on diet, lifestyle and nutritional or herbal supplements and it is my decision whether or not to follow these recommendations. The procedures involved in this treatment have been explained to me. I understand I may be treated with the insertion of needles or other non-insertion techniques; touch/palpation; with the application to the skin. I have not been guaranteed any success concerning the uses and effects of these treatments. I understand that I am free to discontinue treatment at any time.

Possible Side Effects/Healing Reactions

I understand that these treatments may result in certain side effects, including local bruising; slight bleeding; fainting; temporary pain or discomfort; and temporary aggravation of symptoms existing prior to treatment. I further understand that there may be side effects of Moxa sold to and recommended to me such as burning or blistering of the skin as I use this therapy on my own. The ingestion of herbs sold to and recommended to me may cause abdominal discomfort and rarely potential allergies. I understand I am free to discontinue use of Moxa and herbs at any time. Unusual and rare risks of acupuncture include nerve damage, organ puncture, and infection. I have read the information on this page and understand the possible risk involved.

Infectious Disease/Clean Needle Procedures

I understand that there is infectious disease carried through the air, through physical contact, and through body fluids. I understand that universally prescribed precautions will be utilized during treatments to guard against the spread of infection, including the use of sterilized, prepackaged disposable needles. Needles that are used for my treatment are used only on me, and are inserted according to clean procedures based on nationally prescribed standards. Needles are disposed of as medical waste immediately after use.

I understand that my questions about the safety of any procedure or treatment or the precautions taken by the practitioner are most welcome and will be answered as fully as possible.

Medical Referral

I understand that I should consult a licensed physician for appropriate medical evaluation and treatment of the conditions for which I am seeking acupuncture treatment. Treatment from Salem Community Acupuncture does not substitute for appropriate medical treatment by a licensed physician. I have been advised that if there is a worsening of my ailment or condition, or if it does not improve within the time estimated by the acupuncturist at the beginning of treatment, or if a new ailment or condition arises, I should again consult a licensed physician. If I am presently under the medical care of a physician, I have been advised to continue all medications and treatments as prescribed until such time as my physician deems it appropriate to reduce or discontinue the medications
or treatments. I certify that I have informed Salem Community Acupuncture of all physical, mental, and medical conditions, and medications, including possible pregnancy; and that I will notify Salem Community Acupuncture of any changes.

Payment, HIPAA, and Cancellation Policies

Payment is by check, cash, or credit card. **Please make checks payable to SCA.** Full payment is expected at the time services are rendered. A $25 fee is charged for the first check returned by the bank. If a second check is returned, that fee will be charged again and subsequent payments must be cash.

Salem Community Acupuncture has Privacy Practices and Policies in place. We do not share your information without your consent. If you require copies of your records for any reason they will be made available for you to pick up. We are unable to correspond with outside offices on your behalf.

If you must cancel your appointment, call as soon as possible to allow time to reschedule. If you miss your appointment without notifying us, or cancel your appointment with less than 24 hours' notice, we charge a $30 late cancellation fee for that appointment. Exceptions may be made on a case-by-case basis for medical emergencies or natural disasters.

Signature

I understand I have the right to refuse any treatment or procedure. I have read this form carefully. I have felt free to ask any questions, and it has been satisfactorily explained to me.

Signature of Patient or Person Authorized to Consent _____ Relationship of Person Authorized to Consent _____ Date _____