



WELCOME TO HEART CENTERED TRANSFORMATIONAL WELLNESS

Acupuncture Consent to Treatment

I hereby request and consent to the performance of Acupuncture treatments and other Chinese Medicine procedures on me (or on the patient named below, for which I am legally responsible) by the licensed Acupuncturist, Aiden Seraphim L.Ac.

I understand that methods or treatments may include, but are not limited to, Acupuncture, moxabustion, cupping, bloodletting, electrical stimulation, massage, Gua Sha, Chinese or Western Herbal Medicine, nutritional counseling and/or supplementation, yoga and meditation.

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. _____ Initials

The 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 that some supplements may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. If I experience any gastro-intestinal reactions to the supplements I will inform the Acupuncturist immediately. _____ 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 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.

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 agree to pay the full charge for any missed or forgotten appointments without 48- hour notice of cancellation. _____ Initials

I agree to pay all charges incurred for services rendered at time of service, and will request a super bill from the Acupuncturist if I wish to be reimbursed by my insurance company. _____ Initials

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:

Name: _____

Signature: _____

Date: _____