abundant wellness acupuncture | consent form

Name _____ Date_____

Please read this document carefully and completely. Initial wherever indicated. This is an informed consent that explains the expectations and risks associated with Oriental Medicine and Acupuncture Treatments.

Nature of Treatment

Your treatment may include acupuncture, moxibustion, cupping, electric or magnetic stimulation, acupressure, Tui Na (chinese medical massage), Gua Sha (dermal friction), Infra-Red (heat lamps), Chinese herbs, therapeutic exercises and dietary counseling based on the fundamentals of Chinese Medicine.

Purpose of Treatment

The purpose of the treatment is to resolve your complaint, i.e. the reason you are seeking treatment. Acupuncture is a health care service that is based on an Oriental system of medical theory. Diagnosis and treatment, based on these theories, are used to promote health and treat organic or functional disorders. While Oriental medicine has a great deal to offer as a health care system, it cannot replace the care of a medical physician. It is recommended that you consult a physician regarding any conditions for which you are seeking acupuncture treatment(s). This is a recommendation ONLY. The State of MD does not require an MD script for Acupuncture.

Benefit of Treatment

Acupuncture and Oriental Medicine procedures have been used effectively to treat a variety of diseases for hundreds of years. *While we strive to provide the best individualized treatments for our patients, we cannot guarantee the outcome of any course of treatment.*

Risks of Treatment

While acupuncture, Chinese medicine, and other treatments provided by this office have proven to be highly effective in correcting conditions and maintaining overall health and well-being, practitioners are required to advise patients that there may be some risks. Although practitioners cannot anticipate all of the possible risks and complications that may arise with each individual case, you should be aware that the following side effects can occur. If there are particular risks that apply to your case, your practitioner will discuss these with you.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects including bruising, minor bleeding, numbness or tingling at or near the needle site, which may last a few days. I may also experience some muscle soreness and petechiae (due to cupping or gua sha), which may also last a few days. Drowsiness may occur in a small number of patients, and if affected, you are advised not to drive. In a small percentage of patients, nausea can occur and symptoms may become worse

before they improve; this is usually a good sign (it is called the “law of cure”). Please advise your acupuncturist if worsening symptoms continue for more than 48 hours.

An unusual risk of acupuncture includes fainting, spontaneous miscarriage, nerve damage, and organ puncture. Infection is another possible risk, however since **this office uses only sterilized, disposable needles** while maintaining a clean and safe environment, this is unlikely. Burns and scarring are potential risks of using moxibustion. I have been informed I may stop treatment at any time.

I have read and understand the above _____ Please Initial

What your Acupuncturist needs to know:

Apart from your medical history, it is important to tell your practitioner **if you have ever had a fit, fainted or have experienced any odd sensations**. Please let us know **if you have a pacemaker or electrical implants**. Let us know if you have a **bleeding disorder**, are **taking anti-coagulants**, **any other medication, have a risk of infection**, or **have a damaged heart valve.** I will notify the acupuncturist, who is caring for me, **if I become pregnant**.

I have read and understand the above _____ Please Initial

Cancellation Policy

At Abundant Wellness Acupuncture, we strive to provide the highest level of care and service to all our patients. As a small business, we rely on the commitment of our patients to honor their scheduled appointments, just as we do our best to accommodate your needs and provide exceptional care in return. We understand that unforeseen circumstances may arise, and we always strive to be understanding and flexible. However, due to the challenges we face in filling these appointment slots on short notice, we will be charging the **full price of the scheduled treatment for any cancellations made with less than 24 hours' notice**.

We want to emphasize that this policy is **not meant to inconvenience or penalize our patients**. Instead, it is **designed to ensure that we can continue to provide the highest level of care and maintain the availability of our services to all patients**. By adhering to this policy, we can better manage our schedule and allocate our resources effectively.

We kindly request your understanding and cooperation in honoring your scheduled appointments. If you need to reschedule or cancel an appointment, we kindly ask that you provide us with at least 24 hours' notice. This will allow us to offer the appointment slot to another patient who may be in need of our services.

We greatly appreciate your continued support and trust in our practice.

I have read and understand the above _____ Please Initial

Statement of Consent

I confirm I have read and understood the above information, and I consent to having treatments and procedures from Bridget Lanza, L.Ac. I have read the possible risks of treatment outlined above, but do not expect the practitioner to be able to anticipate and explain all of the possible risks and complications of treatment. I wish to rely on the acupuncturist to exercise judgments during the course of treatment, and decide what she thinks is in my best interest, based upon the facts that are known at the time.

I understand the practitioner and administrative staff may review my medical records, but all of 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 this consent form, have been told about the risks and benefits of treatments provided by this office 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 further conditions for which I seek treatment.

Please print your full name _____

Date _____

Patient Signature _____