SOCO CLINIC
INTEGRATED HEALTHCARE

Request & Consent

I hereby 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 William A. Wood, L.Ac or Aaron Winning. L. Ac. 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 William A. Wood, L.Ac or Aaron Winning, L. Ac., including those working at Soco Clinic or any other office or clinic, whether signatories to this form or not.

I understand methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Acupressure (Chinese massage), Chinese 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 and understand that my medical information and Chinese medical treatment information will be used for medical research purposes and may be published in medical journals or educational material for healthcare professionals and researchers. I understand that my real name a contact information will not be used in any publication, and that all my records will be confidential and follow all privacy practices and HIPPA regulations.

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 Chinese 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. I have read, reviewed, understand and agree to the Notice of Privacy Policies for healthcare services in this office.

I understand that I am financially responsible for all charges and for all services rendered on my behalf or my dependents. I agree to pay in full for all charges when services are rendered.

I agree to give 24 hours notice if I am going to be unable to make my scheduled appointment. I fully understand I will be charged the regular fee if I miss an appointment without giving 24 hours notice.

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 at Soco Clinic Integrated Healthcare

I understand and agree that health/accident insurance policies are an agreement between an insurance carrier and myself**.** I understand that my insurance will be billed for services rendered in this office and that I am responsible for any services not paid and/or not covered by my insurance. Furthermore, **I understand pre-approval of insurance is NOT a guarantee of payment. In the event your insurance company refuses to pay this office for treatment, you are responsible for all fees and further insurance appeal becomes your responsibility.** I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment and any fees for collection of past due accounts. I also understand that if I suspend or terminate my care and treatment, fees for services rendered to me will be immediately due and payable.

Permission to Share Medical Information

There are a few instances where sharing information about your case aids in better patient care and better clinical outcome, and we would like to have your permission to share any pertinent information:

Soco Clinic Integrated Healthcare is a multi-practitioner office; do you grant us permission to share information with our counselor, D.O., or MD, if you wish to see them? Circle the following: Yes No
We may want to contact your doctors, or other healthcare providers to send them updates about your progress. Do you grant us permission to discuss the details of your case? Circle the following: Yes No

Patient/Guardian Signature ____ Date ____________________________