Whole Family Wellness Center
Informed Consent to Treatment

I consent to acupuncture treatments and other procedures associated with Traditional Chinese Medicine by Jill Stevens, L.Ac.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese or Western herbal medicine, Homeopathy, Flower Essence Therapy, nutritional supplements and nutritional counseling.

I have had the opportunity to discuss with the practitioner named below the nature and purpose of acupuncture treatments and other procedures.

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. Following an acupuncture treatment, there may be dizziness or fainting. Although the practitioner maintains a clean environment and uses disposable needles, in rare cases infection of the needling site may occur. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping. Burns and scarring are potential side effects of moxibustion.

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that may be recommended are traditionally considered safe in the practice of Chinese medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience gastro-intestinal upset, allergic reactions or any other undesirable effect to the herbs, I will inform the above named practitioner.

I will notify Jill Stevens, L.Ac. if I am or anticipate to become pregnant.

I do not expect Jill Stevens, L.Ac., to be able to anticipate and explain all risks and complications, and I wish to rely on the above named practitioner to exercise judgment during the course of the procedure which she feels at the time, based upon the facts then known, is in my best interest.

I understand that clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent, unless required to do so by law.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and 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.

To be completed by patient:

PATIENT'S NAME________________________________
(please print)

PATIENT'S SIGNATURE___________________________

DATE SIGNED__________________________________

ARE YOU PREGNANT? _____YES _____NO

To be completed by the patient's representative, if necessary, e.g., if patient is a minor or is physically or legally incapacitated:

NAME OF PATIENT________________________________
(please print)

PATIENT'S REPRESENTATIVE_______________________
(please print)

REPRESENTATIVE'S SIGNATURE_____________________

AS:____
Relationship or Authority of Patient's Representative

DATE SIGNED____________________________________

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