Pure Zen
Wellness
Acupuncture & Integrative Medicine Center
Anna Krasheninnikova, L.Ac.

317 North El Camino Real, Suite 104
Encinitas, CA, 92024
Phone: 760.710.0234 Alt. Phone: 760.587.9644
Fax: 760.602.1298
e-mail: anna@purezenwellness.com
web: www.purezenwellness.com

Welcome to Our Practice

Thank you for choosing our office to meet your health care needs. In addition to acupuncture, you will have access to nutritional counseling, herbal medicine, lifestyle counseling, and a broad array of diagnostic testing. Our goal is to provide a safe, healing environment and to support you in your pursuit of optimal well-being.

Your initial visit may take up to two hours. Please plan your schedule accordingly. We will do a thorough health interview and history, and then partner with you to develop a personalized treatment plan. You will have ample time to ask any questions you may have.

Please note that because this time has been reserved especially for you, we request notification of any scheduling changes a minimum of two business days prior to the first appointment, and one business day prior to established patient visits. Any missed appointments are billed at the regular appointment rate.

To help us better serve you, please take some time to complete and sign the enclosed forms before arriving at your first appointment. If you have recent laboratory test results that you would like to review at the initial appointment, please bring copies, or make arrangements to have them faxed to our office.
If you have any questions, feel free to call us.

We look forward to meeting you soon,

Anna Krasheninnikova, L.Ac.

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New Patient Comprehensive Health Packet

This packet contains everything you need to get started, including information about our practice, our policies, directions to the office, and new patient forms.

The forms in this packet are for those coming in for a comprehensive health evaluation. These forms ask for detailed information, so please allow some time to fill them out prior to your initial visit.

A note on labs - in our practice we often make use of a comprehensive set of lab tests to evaluate your health. Please bring any previous lab results that you would like us to review with you to your initial appointment, or make arrangements to have them faxed to our office.

We look forward to meeting you soon.

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About Our Services

We specialize in offering a highly integrated approach to health and wellness, utilizing the best that both Eastern and Western medicine has to offer. Much of what makes our practice unique is a comprehensive process that combines the holistic paradigm of traditional Chinese medicine with the best tools of modern Western science. We begin with a thorough assessment, then create an integrated treatment strategy designed to bring about effective results.

We offer our patients a wide variety of modalities to meet their health care needs:

- Acupuncture
- Herbal Medicine
- Nutritional Counseling & Support
- Lifestyle Counseling
- Stress Management
- Neuro-Emotional Technique
- Nambudripad Allergy Elimination Techniques

Please note: These modalities are described in detail on our website.

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Office Policies and Procedures

Initial Appointment:

- Please allow up to two hours for your initial visit.
- Please arrive 10 minutes early, with your forms completed.
- Any scheduling changes for initial appointments must be made at least 2 business days in advance. Initial appointments that are missed will be charged at the full visit rate.

Cancellations and Changes:

- If you need to reschedule an appointment, please notify us a minimum of 1 business day prior to your scheduled time, so we have time to schedule someone else that is waiting for an appointment.
- If your appointment is on Monday, please notify our office of changes or cancellations no later than noon on the previous Friday.
- Patients who miss their appointment or cancel less than 1 business day prior to their appointment will be required to pay for the missed visit. Missed appointments will be billed to credit card on file.
- Please be respectful to patients on the waiting list, and kindly give us as much advance notice as possible if you need to reschedule.

Your Visits:

- We value our patients' time. In order to keep on schedule, we request that you arrive on time for your appointments. If you arrive more than 15 minutes late for your appointment, it does not allow the necessary time to effectively conduct a treatment and we will need to reschedule you, and will treat it as a missed appointment. We will make every effort to reschedule you ASAP. Please allow sufficient travel time and take traffic conditions into consideration.
- There are occasions where extenuating circumstances arise and we may be delayed for a brief time. This will not affect the length of your visit. Please accept our apologies for any inconvenience.
- Please allow enough time for your complete visit. If you know you need to leave our office by a specific time, please let us know when you first arrive and we will do our best to accommodate you.

Herbs, Supplements & Prescriptions:

- If for any reason you are unable to take your prescribed items as directed or have questions about their use, please let our office know as soon as possible.
- Unopened bottles in resalable condition can be returned for office credit within 30 days of purchase.
- The following items cannot be returned: refrigerated items, special order items, custom formulas.

Payment:

- Payment is due at the time of your appointment, unless alternate arrangements have been made.
- Accepted methods of payment are: **Cash, Check, American Express**, **Visa, MasterCard, Discover.**
- We require all patients to have a current signed credit card authorization form on file to secure your appointments and fulfill your mail-order prescriptions.

Insurance:

We are currently participating with select plans of Cigna and BlueCross BlueShield insurances, all auto-insurances and all worker's compensation claims. Please check with your insurance if your plan includes acupuncture benefits if administered by a licensed acupuncturist. A medical receipt detailing diagnostic codes and fees can be provided to you for each visit. This receipt can be submitted to your insurance carrier. If you have a healthcare savings account or flexible spending plan, we'll be glad to provide you with documentation for your expenditures that you can submit it for reimbursement.

OFFICE POLICIES

Welcome to the Golden Harmony Acupuncture. We want you to be comfortable and to receive the best care possible. Please do not hesitate to ask any questions you might have regarding your visit, your billing, or our policies.

FEES The fees charged in this office are comparable to those charged by other healthcare providers in this area, with similar qualifications. Please ask to see our fee schedule. We accept cash, credit cards, and personal checks. Please note there is a $25.00 charge for checks returned due to insufficient funds.

Initial_____

INSURANCE COVERAGE Many insurance policies cover Acupuncture, but we do not claim that yours does. Policies can differ greatly in terms of deductible and percentage of coverage for Acupuncture. We can verify coverage and submit your claim form for reimbursement, provided you sign financial agreement below.

Initial_____

RELEASE OF INFORMATION Your insurance company may require medical reports to document our treatment and progress. Your initials below authorize the release of medical information necessary to process your claim.

Initial_____

CANCELLATIONS As a courtesy to our office and other patients, we ask that you please notify the office at least 24 hours in advance if you need to cancel or reschedule your appointment. You will be charged a $40.00 fee for any missed appointment or cancellation giving less than 24 hours notice for any non-emergency situations

Initial_____

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS

I, (print full name) _____, am receiving or about to receive health care services in this office. I understand that I am responsible to pay all non-insurance related fees when services are rendered, including herbs, etc. If I choose to use my insurance I understand I will be responsible for all "non covered" services and /or coinsurance/co-pays associated with my office visit. In addition I authorize insurance payment of medical benefits to Albina Tong – Golden Harmony Acupuncture.

By signing below, I agree to comply with the office policies stated above which I have read and understood. I also authorize the use of this signature on all insurance submissions.

Signed_____ Date_____

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Patient Information

Today's date: _____

Name: _____ Birth date: _____Age: _____

Street Address: _____City:_____ Zip:_____

Home phone: _____ Cell Phone: _____

Work Phone: _____ E-mail Address: _____

Occupation: _____ Employer: _____

Insurance Carrier: _____ Policy number: _____

Marital Status: single married divorced separated in a relationship N/A

Emergency contact:

Name: _____ Phone: _____ Relationship: _____

How did you hear about our center: _____

Referred by _____

May we send a thank you card? Yes No

Primary treating physician: _____ Phone: _____

Other specialist: _____ Phone: _____

Other specialist: _____Phone: _____

Have you ever been treated with acupuncture? Yes No

If yes, condition treated? _____

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Credit Card Authorization

We require a current credit card number on file to secure your appointments and for any mailed prescriptions or special orders. We will never charge this number without giving you prior notice.

I, (print name)_____ authorize Anna Krasheninnikova, L.Ac, 1114 North Coast Highway 101 Suite 1A Encinitas, CA, 92024 to bill my credit card as listed below:

Name on Credit Card _____

Credit Card Details

Circle one: Visa MasterCard American express Discover

Card # _____

Expiration Date: _____

CVS code (3 digit security code on back of card)**:** _____

Billing Address

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone (include area code)**:** _____

AUTHORIZATION

X_____
Cardholder's signature Today's date

This authorization can be revoked upon your written notice to our office.

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Informed Consent

I hereby request and consent to the performance of acupuncture treatments, other Oriental Medicine and/or Functional/Energetic Medicine procedures by the licensed practitioner listed below. I understand that the treatment may include, but not limited to: acupuncture, acupressure, moxibustion, cupping, heat lamp, Chinese or Western herbal medicine, homeopathy, nutritional testing or kinesiology. I have had an opportunity to discuss with the practitioner named below the nature and purpose of these treatment modalities and other procedures. I understand that results are not guaranteed.

Acupuncture: I have had an opportunity to discuss with a practitioner the nature and purpose of said treatment and/or 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 may last a few days. **Initial here_____.**

Neuro-Emotional Technique (NET): Emotions have a psychological aspect, however this technology is not psychology or psychiatry. Psychological aspects of emotional health will be referred out to an appropriate health care professional. Additionally, this technology does not deal with the spiritual realm. It does not make claims as to what events may have historically happened in the past. It does not tell people what their psychological plan of action may, must, or should be for the future.. **Initial here_____.**

Nambudripad Allergy Elimination technique (NAET): I understand that once I have been cleared for a sensitivity to an allergen, it is my responsibility to recheck the clearing within one week. I understand that I may still have a reaction to that allergen if it is not cleared and additional treatment sessions may be necessary to clear the allergen completely. **Initial here_____.**

Nutritional Response Testing (NRT): I understand that this technique will test for the nutritional supplements which my body may be craving to reach maximum health benefits from nutrition. I understand that the supplements selected are not a replacement for my regular medications, and that I will not make any changes regarding the prescribed medications without discussing it with my medical doctor. **Initial here_____.**

To present, there may not be formal scientific studies completed for my particular condition now or those conditions that are treated in the future with these technologies. I understand that my return to health is a process of brining my body into harmony with the bodies own ability to heal. **Initial here_____.**

I understand the contents of this consent form; and I have had an opportunity to ask questions about this consent. By signing below I agree to the above named procedures.

_____	_____	_____
Patient's Printed Name	Patient's Signature	Date
_____	_____	_____
Parent's or Authorized Person's name	Parent's Signature	Date

Practitioner: Anna Krasheninnikova, L.Ac.

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Health History

Name: _____Today's Date: _____

Reason for visit: Please list your 5 major health concerns in order of importance:

1. _____

2. _____

3. _____

4. _____

5. _____

Major hospitalizations, surgeries, illnesses, injuries:

Year	Surgery, illness, injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest):

1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Height: _____ Weight: _____ BMI: _____

Do you consider yourself: Under-weight Over-weight Just right

Have you experienced unexpected weight gain or weight loss of greater than 10 pounds in the last three months?

Yes No If yes, how much? _____

Do you smoke? Yes No If yes, how much per day? _____ Per week? _____

Do you drink alcohol? Yes No Type: _____ Quantity: _____

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Medications & Supplements

Please list any known allergies:

_____

_____

_____

Please list all current medications that you are taking:

Start date:	Item:	Amount:	Frequency:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list all current vitamin supplements and herbs that you are taking:

Start date:	Item:	Amount:	Frequency:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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The following questions are for female patients only:

Are you pregnant? _____ Any chance you could be pregnant? _____

Describe your menstrual cycles REGULAR IRREGULAR EARLY LATE

_____

Is your menstrual flow NORMAL LIGHT HEAVY WITH CLOTTS ?

Is the blood BRIGHT RED PURPLISH DARK LIGHT in color?

Is your vaginal discharge CLEAR-THIN WHITE or YELLOW-THICK ?

Do you experience PMS? Please describe _____

Number of Pregnancies: _____Number of childbirths _____

Have you had fertility therapy in the past? _____ Present _____

What type of fertility therapy? _____

Type of birth control used in the past _____ Present _____

Do you have problem with conceiving _____ infertility _____

Do you have signs and symptoms of menopause?

Hot Flushes Spontaneous Sweating Weight gain Headaches Vaginal Bleeding

Other symptoms: _____

Please describe any other GYN/ obstetric issues you may have

_____

_____

Reviewed by: _____ Date _____

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Medical History

- ❑ Arthritis
- ❑ Allergies/hay fever
- ❑ Asthma
- ❑ Alcoholism
- ❑ Bladder problem
- ❑ Blood pressure: low
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chronic fatigue
- ❑ Carpal tunnel
- ❑ Cholesterol elevated
- ❑ Circulatory problems
- ❑ Cloudy thinking
- ❑ Colitis
- ❑ Constipation
- ❑ Debilitating fatigue
- ❑ Dental problems
- ❑ Depression
- ❑ Diabetes
- ❑ Diarrhea, chronic
- ❑ Diverticulitis
- ❑ Dizziness, chronic
- ❑ Drug addiction
- ❑ Drug use
- ❑ Eating disorder
- ❑ Epilepsy
- ❑ Emphysema
- ❑ Eyes, ears, nose problems
- ❑ Environmental sensitivities
- ❑ Fibromyalgia
- ❑ Food intolerance
- ❑ Gastric reflux
- ❑ Genetic disorder
- ❑ Gout
- ❑ Headache: migraine
- ❑ Headaches: stress
- ❑ Heart disease
- ❑ Hypertension
- ❑ Infection, chronic
- ❑ IBS
- ❑ Insomnia, chronic
- ❑ Kidney disease
- ❑ Liver or gallbladder disease (stones)
- ❑ Nausea, chronic
- ❑ Vomiting, chronic
- ❑ Neurological issues
- ❑ Panic attacks
- ❑ Pain, chronic
- ❑ Shortness of breath
- ❑ Sinus problems
- ❑ Stroke
- ❑ Thyroid trouble
- ❑ Obesity
- ❑ Osteoporosis
- ❑ SAD disorder
- ❑ Skin problems
- ❑ Ulcer
- ❑ Urinary tract infctn
- ❑ Varicose veins
- ❑ Other

_____
_____

Family Health History (Parents & Siblings):

- ❑ Arthritis
- ❑ Asthma
- ❑ Autoimmune disordr
- ❑ Cancer
- ❑ Diabetes
- ❑ Drug addiction
- ❑ Heart disease
- ❑ Obesity
- ❑ Stroke
- ❑ Other

Exercise:

- ❑ 5-7 days per week
- ❑ 3-4 days per week
- ❑ 1-2 days per week
- ❑ 45 minutes or more duration per workout
- ❑ 30-45 minutes durat.
- ❑ Less than 30 min
- ❑ Walk
- ❑ Run, jog, jump rope
- ❑ Weight lift
- ❑ Swim
- ❑ Cycle
- ❑ Yoga
- ❑ Other

_____

Nutrition and Diet:

- ❑ Omnivore (animal & vegetable sources)
- ❑ Vegetarian
- ❑ Vegan
- ❑ Processed foods
- ❑ Whole foods
- ❑ Specific food restrictions:
- ❑ Dairy
- ❑ Wheat
- ❑ Eggs
- ❑ Soy
- ❑ All Gluten
- ❑ Other

_____

Food Frequency

How many servings per day?

_____Fruits
_____Vegetables
_____Grains
_____Beans and peas
_____Nuts and seeds
_____Dairy
_____Eggs
_____Meat
_____Poultry
_____Fish

Eating Habits:

- ❑ Skip breakfast
- ❑ Eat three meals/day
- ❑ Eat two meals/day
- ❑ Eat one meal/day
- ❑ Graze (small meals)
- ❑ Eat constantly
- ❑ Eat on the run
- ❑ How many times do you eat out per week?

_____

- ❑ How many alcoholic beverages do you consume in a week?

_____

- ❑ How many caffeinated beverages do you consume per day?

_____

Would You Like To:

- ❑ Have more energy
- ❑ Be stronger
- ❑ Have more endurance
- ❑ Increase your sex drive
- ❑ Be thinner
- ❑ Be more muscular
- ❑ Improve complexion
- ❑ Have stronger nails
- ❑ Have healthier hair
- ❑ Be less moody
- ❑ Be less depressed
- ❑ Be less indecisive
- ❑ Feel more motivated
- ❑ Be more organized
- ❑ Think more clearly and be more focused
- ❑ Improve memory
- ❑ Not be dependent on over the counter medications like aspirin, ibuprofen, antihistamine sleeping aids, etc
- ❑ Stop using laxatives or stool softeners
- ❑ Be free of pain
- ❑ Sleep better
- ❑ Have agreeable breath
- ❑ Have agreeable body odor
- ❑ Have stronger teeth
- ❑ Get less colds and flues
- ❑ Get rid of your allergies
- ❑ Reduce your risk of inherited disease tendencies (i.e. cancer, heart disease, etc.)

Effective Date: November 1, 2014

Notice of Patient Privacy
Health Insurance Portability and Accountability Act (HIPAA)

Pure Zen Wellness Clinic is dedicated in preserving your personal health information. We are required by law to protect your personal medical information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information.

Required by law: We must have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.
We may be required by law to use and disclose your medical information for other purposes without your consent or authorization.
You are provided the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining an accounting of or disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The Effective Date at the top right-hand side of this page indicates the date of the most current NOTICE in effect.

You have the right to receive a copy of our most current NOTICE in effect. If you have not yet received a copy of our current NOTICE, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the NOTICE or your medical information, please contact Pure Zen Wellness 317 North El Camino Real, Encinitas, California 92024. You may also send a written complaint to the US Department of Health and Human Services.

_____ _____

Patient Signature Date

_____

Printed Name

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE **X**

.

ALSO **SIGN** THE **INFORMED CONSENT** ON **REVERSE** SIDE

ACUPUNCTURE INFORMED CONSENT TO TREAT

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 the acupuncturist indicated below 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 the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (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 have 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 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. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. 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.

I understand that while this document describes the major risks of treatment, other side effects 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.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, 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.

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.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE