CONSENT TO TREATMENT

Acupuncture: I understand that acupuncture is performed by the insertion of PRE-STERILIZED, DISPOSABLE needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Gua Sha/cupping: I understand that I may also be given gua sha and/or cupping as part of my treatment to promote circulation and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

Moxibustion Includes the application of heat to acupuncture points, and other areas of my body, by manipulating a burning herb, in various ways, to allow the heat to warm and penetrate my skin. I understand that this treatment includes the application of burning moxa near my skin. I understand that this procedure is not intended to result in burns and scarring, but that burning and scarring is a possibility. I understand that I may refuse this treatment or stop it if it becomes too uncomfortable.

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. I understand the same herbs may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. If I experience any gastro-intestinal reactions to the herbs I will inform the acupuncturist *immediately*

The benefits and risks of receiving acupuncture and Oriental Medicine treatment have been explained to me. Although rare, certain side effects may result from acupuncture.
I understand that each procedure or treatment has specific risks and benefits.

I understand that methods or treatments may include but are not limited to acupuncture, moxibustion, cupping, bloodletting, electrical stimulation, Tui Na (Chinese massage) Gua Sha, Chinese or Western herbal medicine, and nutritional counseling.

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 content, 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. _____**initials**

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 an 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. _____**initials**

I agree to pay the full charge for any missed or forgotten appointments without 24-hour notice of cancellation. _____**initials**
(notice must be provided in person or by telephone- not via email or text)

I understand that New Earth Acupuncture & Nutritional Wellness does not accept health insurance, but will furnish me with a receipt for services if I so request. _____**initials**

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Patient's Signature: _____Date: _____

Witness Signature: _____Date:_____

Notice of Privacy Practices:
I have received a copy of the New Earth Acupuncture & Nutritional Wellness Notice of Privacy Booklet. I understand this booklet defines my rights under CFR 164.528 of the federal regulations and is intended to comply with federal patient privacy rights.

Patient's Signature: _____Date: _____

Witness Signature: _____Date:_____

CONSENT TO TREAT A MINOR CHILD

I authorize Monica A. Judge and New Earth Acupuncture & Nutritional Wellness, LLC to administer Acupuncture and Nutritional Wellness care as deemed necessary to my _____ (relationship). Patient Name_____

Adult's Signature _____Date_____