RIVERTOWN ACUPUNCTURE

Advisory to Consult Physician

While Classical Chinese Medicine has a great deal to offer as a health care system, it cannot replace the resources available through medical physicians. It is recommended that you consult a physician regarding any conditions for which you are seeking acupuncture treatment(s).

I, (print name) _____ have been advised by Randi Marie Hoffmann, L.Ac. to consult a physician regarding the conditions, for which I seek acupuncture treatment(s).

_____

Signature of patient or patient representative Date

_____

Signature of Practitioner Date

Cancellation Policy

I agree to pay for the appointment if I do not comply with notifying Randi Marie Hoffmann within 24 hours before my scheduled appointment time.

_____

Signature of patient Date

Informed Consent

I understand that by voluntarily signing this form, I consent to acupuncture treatments and related procedures as defined by Classical Chinese Medicine, to be performed by Randi Marie Hoffmann, Ac. I understand that the method of treatment may include but is not limited to acupuncture, acupressure, tui na, moxibustion, cupping, gua sha, electrical stimulation and herbal liniments.

I have been informed that there may be adverse effects to acupuncture which could include but are not limited to local bruising, mild pain in the area treated, sore or aching muscles, brief generalized fatigue, and tingling or numbness. I will notify the acupuncturist who is caring for me if I become pregnant, as I understand that an unusual side effect of some acupuncture points may stimulate spontaneous miscarriage. Other possible risks may include nerve damage, organ puncture and infection; 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 understand that I am encouraged to communicate any discomfort I may feel during the needling process, so that the needles can be adjusted and/or removed. I also understand that there are no guarantees concerning the use of acupuncture and its effects. I have been informed that I am free to stop treatment at any time, as well as free to refuse any modality that may be offered as part of the treatment.

I understand that I should not change my position nor move suddenly while the needles are in place. I understand that it is important for me to maintain good personal hygiene. I understand that I will not be treated if I am intoxicated and/or are abusing substances.
I understand that payment is due upon receipt of services.

By voluntarily signing below, I show that I have read or have had read to me this consent to treatment. I have been told about some of the risks acupuncture and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for both the present condition and for any future conditions for which I seek treatment(s).

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Signature of Patient or Patient Representative Date