www.GreenSpaNY.com | 8804 3rd Avenue, Brooklyn, NY 11209 | 718.921.6100

I. PATIENT ADVISORY TO CONSULT A PHYSICIAN

______________________________ (Licensed Acupuncturist) is committed to your health and well-being. And while Oriental Medicine has a great deal to offer as a health care system, it cannot totally replace the resources available through biomedical physicians. Consequently, it is recommended that you consult a physician regarding any condition or conditions for which you are seeking acupuncture treatment.

To comply with Article 160, Section 821 1.1 (b) of NYS Education law, we request that you read and sign the following statement:

WE, THE UNDERSIGNED, DO AFFIRM THAT ______________________________(patient) HAS BEEN ADVISED BY: __________________________________ (Licensed Acupuncturist) TO CONSULT A PHYSICIAN REGARDING THE CONDITION (S) FOR WHICH SUCH PATIENT SEEKS ACUPUNTURE TREATMENT.

____ ____________________

Patient Signature **Date**

____ ____________________

Licensed Acupuncturist/Clinician Signature **Date**

II. INFORMED CONSENT TO ACUPUNCTURE TREATMENT

I hereby request and consent to acupuncture treatment and other procedures associated with the practice of Traditional Oriental Medicine provided by __________________________________.
I have discussed the nature and purpose of my treatment with the Licensed Acupuncturist.
I understand that methods of treatment may include but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, and bodywork therapies such as Medical Massage, Tui Na (Chinese Massage) and Shiatsu.

I have been informed that acupuncture is a safe method of treatment. Acupuncture therapy may involve the insertion and stimulation of several sterile and disposable needles into the skin. Acupuncture therapy may have side effects, including bruising, soreness, tingling or superficial bleeding are occasional occurrence near the needling sites that may last a few days. Bruising is a common side effect of cupping. Infection is another possible risk, although this site uses sterile, disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

The herbs and nutritional supplements (from plant, animal and mineral sources), which may be 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, diarrhea, rashes, hives and tingling of the tongue. I understand that the herbs may need to be prepared and the tea consumed according to the instructions provided orally and/or in writing.

The herbs may have an unpleasant smell or taste. I will immediately notify Licensed Acupuncturist of any unanticipated or unpleasant effects associated with the consumption the herbal supplements.

I will notify the Licensed Acupuncturist, who is caring for me if I am, or become pregnant.

I do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on the Licensed Acupuncturist to exercise judgment during the course of treatment which the Licensed Acupuncturist thinks at the time, based upon facts known to him/her, is in my best interest.

I understand the clinical and administrative staff may review my medical records. All of my records will be kept confidential and will not be released to any party without my written consent.

III. INSURANCE ADVISORY

I understand that ________________________________ **(Licensed Acupuncturist)** is not able to provide insurance billing.

By voluntarily signing below I show that I have read, or have had read to me in my native language, this 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.

To be completed by patient (or patient's representative if the patient is a minor or is physically or legally incapacitated).

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Date Consent Completed

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Print Name of Patient

____

Signature of Patient or Representative

____

Print Name of Patient Representative (if applicable)

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Print Name of Licensed Acupuncturist

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Signature of Licensed Acupuncturist