INFORMED CONSENT TO ORIENTAL MEDICINE HEATH CARE

I hereby request and consent to the performance of acupuncture and other Traditional Chinese Medicine (TCM) treatments on me (or on the patient named below, for whom I am legally responsible) by the licensed acupuncturists who now or in the future treat me while on staff with Element 5 OM.

I understand that the scope of the practice under Element 5 OM includes but is not limited to: acupuncture, herbal therapy and other oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle, and orthopedic testing; modes of manuals or physical therapy such as massage, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation; the prescription of herbal and homeopathic medicines as well as dietary supplements and dietary recommendations, exercise, discussion and advice regarding thoughts, feelings, sensations, emotions and attitudes, and healthy life style counseling.

I understand and am informed that, as in the practice of allopathic medicine, in the practice of Oriental Medicine there are some risks with treatment. I understand that although the risk of avert side effects are extremely minimal, they are possible. This could include, but are not limited too: bruising, bleeding, skin irritation, pain in the treated area, muscle weakness and soreness, brief generalized fatigue or nausea, sensations of heat or cold, tingling or numbness, brief lightheadedness or fainting, broken needles and risks of infection or pneumothorax, and the possible aggravation of symptoms existing prior to acupuncture treatment or creation of new symptoms. 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.

By signing this consent form I acknowledge that I have read this informed consent form, or it has been read to me, and I fully understand the nature, purpose and risks of acupuncture and other oriental medical procedures. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications associated with treatment at Element 5 OM. I wish to rely on my acupuncturist and their judgment in my best interest, based on the facts I have given them, during the entire course of my treatment. I have had an opportunity to ask questions about this form's content, and by signing below I agree to the named procedures. I intend this consent form to cover the entire course of treatment for my present and any future conditions for which I seek treatment at Element 5 OM.

HIPAA AND PRIVACY PRACTIES

A record is made each time you visit this clinic. Your symptoms, the acupuncture's judgment, and a plan of treatment are recorded. This record serves as a basis for planning your care and treatment at future visits. Your health record is the physical property of this clinic, but the content is about you, and therefore belongs to you. You have the right to review or obtain a paper copy of your health record. You have the right to request restrictions on certain uses and disclosures of your information. By signing this consent form you agree that you may be contacted by staff members in regards to appointments or information related to treatments. If this contact is unavailable by phone, the staff member may leave a message with an answering machine or anyone who answers the phone.

This clinic is required to maintain the privacy of your health information with this notice of our privacy practices. We are required to follow the terms of this notice and to notify you if we are unable to grant your request to disclose or restrict disclosure of our health information to others. Other than for the reasons described in this notice, this clinic agrees not to use or disclose you health information without your authorization.

By signing this consent form I acknowledge that I have read, or it has been read to me, and I fully understand the Privacy Practices regarding disclosure and patient health information.

_____

Signature

_____

Printed Name

_____

Signature of Patient's Representative

_____

Printed Name of Patient's Representative

_____

Relationship or Authority of Patient's Representative

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Date Signed