Living Well Acupuncture LLC **Consent to Treat** **Cortney Singleton, AP 3568**

Name: ____ Date:____________________

Home Address: ____

PhoneNumber:______________________________Email:________________________________

Age: _________ Date of Birth: ____________________________ Gender: ◻ Male ◻ Female

Height: _________ Weight: _________ Emergency Contact: _______________________________

Relationship: _____________________ Primary Contact Number: __________________________

How did you hear about us? ____

Do any of the following conditions apply?

Pregnant/ Pacemaker/ HIV /Hepatitis/ Blood Transfusion/ High Blood Pressure/ Infectious Disease/ Cancer/ Asthma/ Emotional Disorder/ Seizures/ Other: ______________________________________

Current Medications (dosage) and Supplements:

____

____

Reason For Visit:

____

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____

____

When did it begin/ how long have you had this condition?

____

Circle to describe pain: Fixed/ Moves/ Radiates/ Sharp/ Dull/ Swelling/ Stiffness/ Burning/ Spasm

Other: ___________________________________ Pain Level 1-10 (extreme): ________________

Have you had acupuncture before? ________ Condition? ____________ Was it affective? ___________

Energy Level? Please circle: High/ Medium/ Low

What is your ideal outcome of your visit today and what is the most important concern to be addressed?

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Cancellation Policy: Appointments cancelled day and or no show of unless emergency will be charged 100%. Cancellations with less than 24 hour notice will result in a $50 fee.

You will be issued an invoice if credit card is not on file.

Initial Here:

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 Jennifer Cortney Singleton, AP. 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, nutritional counseling, acupoint injection therapy, vitamin B-12 Injectables, Tri Immune, lipotropic and homeopathic remedies. 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. Bruising and 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 only sterile, single use, disposable needles and maintains a clean and safe environment. Burns, blisters and/or scarring are a potential risk of moxibustion and cupping and heat/light therapy. 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. 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. I will notify a clinical staff member who is caring for me if I have a severe bleeding disorder, have a history of seizures, a pace maker, Hepatitis C, AIDS or and blood borne condition PRIOR to any treatment. I do not expect Jennifer Cortney Singleton, AP to be able to anticipate and explain all possible risks and complications of treatment, and 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 on the facts then known is in my best interest. I understand the results are not guaranteed. I understand the clinical and administrative staff may review my patient records and lab reports and 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(s) for which I seek treatment. I understand that there is neither an implied nor stated guarantee of success or effectiveness of treatment. I hereby authorize Jennifer Cortney Singleton, A.P. to release any information regarding my condition to the referring physician(if any) and/or to my insurance for the processing of any claim. I also authorize Jennifer Cortney Singleton, A.P. to obtain my medical records from other physicians/medical centers.

Possible Side Effects and Contraindications of B12 and or Lipotropic B12 injection which contains B12, B6, Inositol, Choline and Methionine. A vitamin B12 shot is safe and generally has no side effects, even in higher doses. Some redness and swelling at the injection site may occur. Nerves and blood vessels are not visible and it is possible to aggravate or nerves which could result in paresthesia or peripheral neuropathy. In rare cases, B12 can cause diarrhea, peripheral vascular thrombosis, itching, transitory exanthema, urticaria, feelings of swelling of the whole body and a tinge of pink in urine. Sensitivity to cobalt and/or cobalamin is a contraindication. People with chronic liver and/or kidney dysfunction should not take frequent B12 injections and is contraindicated in Leber's disease; therefore we ask that you please provide us with a recent copy of lab work, which reflects liver and kidney function. This lab work is usually referred to as a metabolic panel. If you have not checked your lab work recently, it is the patients responsibility to complete blood workup as soon as possible or to proceed with injection at your own risk. Interactions with drugs: Chloramphenicol can impede on the red blood cell producing properties of B12. Other drugs that decrease or reduce absorption of B12: antibiotics, cobalt irradiation, colchicine, colestipol, H2-blockers, metformin, nicotine, birth control pills, potassium chloride, proton pump inhibitors such as Prevacid, Losec, Aciphex, Pantaloc, and Zidovudine.

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist. 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 appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: 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 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. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue. 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, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure. I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements

Initial Here:

being taken currently (prescription and over-the-counter). 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. I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit. By voluntarily signing below, I confirm 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 agree with the current or future recommendations for care. 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.

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.

Patient Signature:____Date:___________

Patient Printed Name: ____

Legal Guardian Name and Signature:____

Physician Signature: ____

Initial Here: