

cass hicks acupuncture

INFORMED CONSENT TO TREATMENT

I consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or the patient named below, for whom I'm legally responsible) by Cass Hicks L.Ac.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Chinese herbal medicine and nutritional counseling.

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 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 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.

I will notify Cass Hicks L.Ac. if I am or become pregnant; if I have a pacemaker or any other electrical implants; if I have a bleeding disorder; if I am taking anti-coagulants or any other medications; if I have damaged heart valves or have any particular of infection.

I do not expect that Cass Hicks L.Ac. to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the above named practitioner to exercise judgment during the course of treatment which she thinks at the time, based upon facts then known, is in my best interests.

I understand that 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 as part of my healthcare, Cass Hicks, L.Ac. originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of HIPAA Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Cass Hicks, L.Ac. reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

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 to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

X _____ X _____
SIGNATURE OF PATIENT (OR REPRESENTATIVE) CASS HICKS L.Ac

X _____ X CASS HICKS L.Ac.
PRINT NAME OF PATIENT (OR REPRESENTATIVE)