MARISA DALPAN, DOM

www.marisadalpan.com Mobile: 917-208-2506

INFORMED CONSENT TO ACUPUNCTURE & HERBAL MEDICINE TREATMENT

I consent to acupuncture and herbal treatments and other procedures associated with Chinese Medicine by the acupuncturist named below. I understand that methods of treatment may include, but are not limited to, acupuncture, cupping, gua sha, electrical stimulation, herbal medicine, and nutritional counseling.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases and imbalances of the; body most people experience a sense of well-being and relaxation during and after the treatment. I have been informed that occasionally bruising (hematoma), puffiness, numbness, or tingling at the site of the needle insertion may occur after treatment. Bruising is also a possible side effect of cupping and gua sha. Rare side-effects including dizziness or fainting, especially if the patient is overdue for a meal. Burns on the skin are a potential risk of moxibustion; again, this rarely happens. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I have been informed that Acupuncture may be contraindicated under the following conditions: over exhaustion, too weak, or famished; extreme emotional distress; after three months of pregnancy. I will notify the Acupuncturist if I am or become pregnant, since this will effect the treatment.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then know, is in my best interests.

I understand that 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, this consent to treatment, have been told about the risks and benefits of acupunctures and other procedures, and have had the 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.

Wellness & Energetic Consulting Consent

In participating in Wellness and Energetic Consulting, I take personal responsibility for my well-being and with respect for myself I gratefully accept control of my choices, I take full responsibility and am responsible for all liability for loss or injury incurred while in association with or applying wellness recommendations and energy techniques and information learned through consultations.

I have carefully read this agreement and fully understand its content. I am aware that this is a waiver and release of potential liability and a contract between the above noted parties and myself. I understand that this contract is binding and acknowledge that I am signing this of my own free will.

HIPAA Notification

Our Notice of Privacy Practices provides information about how we may used and disclose protected health information about you. The Notice of contains a Patient Rights Section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do so, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent.

PATIENT ADVISORY TO CONSULT A PHYSICIAN

As a health care practitioner, my primary concern is in your health and well-being. While Oriental Medicine has a great deal to offer as a health care system, it does not replace the abilities of the Western biomedical system. Therefore, I highly recommend that you consult your primary care physician for any condition for which you are seeking acupuncture or herbal medicinal treatment.

By voluntarily signing below, I shot that I have been advised by Marisa DalPan, DOM to consult a physician regarding the condition or conditions for which such patient seeks treatment.

Print Name of Patient or Legal Guardian	Date
Signature of Patient or Legal Guardian	Date
Marisa Giuliana DalPan, AP	Date