INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or the patient named below, for whom I am legally responsible) by the licensed acupuncturist who now or in the future treats me while employed by, 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, moxibustion, cupping, acupuncture, 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 herbs.

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, dizziness or fainting, burns and/or scaring 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 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.

I understand that while this document describes 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. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

If I am being treated for induction of labor of my pregnancy, I understand this procedure, while traditionally practiced as part of TCM, is considered an experimental procedure. I waive my right to any legal claim that may arise through this treatment. I agree to hold Medical Massage & Acupuncture harmless for any and all complications that may occur to me or my child as a result of acupuncture labor induction.

While I do not expect 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 know, and is in my best interest. I understand that results are not guaranteed.

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.

By voluntarily signing below, I show that I have read or have 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 and for any future condition(s) for which I seek treatment.

>>Acupuncturists of Medical Massage & Acupuncture

Signature: __________________________________________ Date: __________________________
East Asian medicine means a health care service using East Asian medicine diagnosis and treatment to promote health and treat organic or functional disorders.

- My qualifications include the following education and license information:
  - **Kim Wilson**, Washington State East Asian Medicine Practitioner/Acupuncture License #AC60241994. Didactic and clinical training in Acupuncture and East Asian Medicine at Middle Way Acupuncture Institute in Mount Vernon, WA.
  - **Kerry Dyer**, Washington State East Asian Medicine Practitioner/Acupuncture License #AC0002782. Didactic and clinical training in Acupuncture and East Asian Medicine at Oregon College of Oriental Medicine in Portland, OR.
  - **Morgan Tougas**, Washington State East Asian Medicine Practitioner/Acupuncture License #AC00002943. Didactic and clinical training in Acupuncture and East Asian Medicine at Seattle School of Oriental Medicine Seattle, WA.
  - **Bobbi Jo Epperson**, Washington State East Asian Medicine Practitioner/Acupuncture License # AC60499458. Didactic and clinical training in Acupuncture and East Asian Medicine at Seattle Institute of Oriental Medicine Seattle, WA.

- The scope of practice for an East Asian medicine practitioner in the state of Washington includes the following:
  - Acupuncture, including the use of acupuncture needles or lancets to directly or indirectly stimulate acupuncture points and meridians;
  - Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians;
  - Moxibustion;
  - Acupressure;
  - Cupping;
  - Dermal friction technique;
  - Infra-red;
  - Sonopuncture;
  - Laserpunctuer;
  - Point injection therapy (aquapuncture); and
  - Dietary advice and health education on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements;
  - Breathing, relaxation, and East Asian exercise techniques;
  - Qi gong;
  - East Asian massage and Tui na, which is a method of East Asian bodywork, characterized by the kneading, pressing, rolling, shaking, and stretching of the body and does not include spinal manipulation; and
  - Superficial heat and cold therapies.

- Side effects may include, but are not limited to:
  - Pain following treatment;
  - Minor bruising;
  - Infection;
  - Needle sickness; and
  - Broken needle

- The patient must inform the East Asian medicine practitioner if the patient has a severe bleeding disorder or pace maker prior to any treatment.
MEDICAL MASSAGE & ACUPUNCTURE P.S.

TREATMENT INFORMATION

Date of your last Physical Exam: ________________________ Results: ________________________________________

Height: ____________________________________________ Weight: ________________________________________

List stress reduction & exercise activities. Please include frequency: ___________________________________________

☐ Yes ☐ No | Do you smoke cigarettes? If yes, how many per day? ___________________________________________

☐ Yes ☐ No | Do you drink alcohol? If yes, how much per week? ___________________________________________

☐ Yes ☐ No | Do you drink coffee/tea/cola? If yes, how much do you drink per day? __________________________

☐ Yes ☐ No | Are you currently seeing a medical practitioner?
If yes, please explain: ________________________________________________________________________________

☐ Yes ☐ No | Do you take any medications? Please include medications, vitamins, herbs, etc.
If yes, please list medication and condition: __________________________________________________________

☐ Yes ☐ No | Do you have high or low blood pressure? ______________________________________________________

☐ Yes ☐ No | Do you have an infectious or contagious disease? If yes, please explain: _______________________

☐ Yes ☐ No | Are you pregnant? If yes, how many weeks? _____________________________________________

WASHINGTON STATE LAW REQUIRES THAT YOU LET US KNOW ABOUT ANY POTENTIALLY SERIOUS DISORDERS THAT YOU HAVE:

Yes  No  | Do you have a cardiac condition?

Yes  No  | Do you have uncontrolled hypertension?

Yes  No  | Are you experiencing acute abdominal symptoms?

Yes  No  | Are you experiencing acute undiagnosed neurological changes?

Yes  No  | Have you experienced a weight loss or gain in excess of 15% of body weight within a 3-month period?

Yes  No  | Do you have a suspected fracture or dislocation?

Yes  No  | Do you have a suspected systemic infection?

Yes  No  | Are you experiencing acute respiratory distress without previous history or diagnosis?

Yes  No  | Do you have any other potentially serious disorder?
If so, what? ________________________________________________________________________________________________
I (patient/parent/guardian) agree to massage therapy, acupuncture treatment and procedures that are provided by an authorized employee of Medical Massage & Acupuncture.

I agree to authorize all insurance benefits to pay directly to Medical Massage & Acupuncture.

I understand that Medical Massage & Acupuncture has the authority to release any information necessary to the insurance company for the processing of medical claims.

As a courtesy, Medical Massage & Acupuncture will obtain a verification of applicable insurance benefits as they are quoted to them, but some third party payers misquote benefits, coverage and liability. The facility & staff are not responsible for what a third party payer and/or representative may tell them. Any contractual, written, verbal or other obligations or arrangements between me and an attorney, insurance company, liable or third party payer are between me and said person.

I understand that my insurance policy is a contract between patient and insurance company. Medical Massage & Acupuncture is not a party to that contract. It is my responsibility to be familiar with my insurance policy.

While Medical Massage & Acupuncture is happy to submit my claims to my insurance on my behalf, payment for medical services provided is my responsibility. Copays are due at the time of service. I understand that I am financially responsible for all charges that have been incurred for medical services rendered on my behalf. If my health insurance denies my medical claims, I understand I am responsible for the cost of the massage therapy and/or acupuncture treatment. Any amounts left owing after insurance reimbursement is made are also my responsibility.

Should my account be referred for collection, I am responsible for reasonable attorney fees and collection expenses. All delinquent accounts bear interest at the legal rate. In the event of court action, venue and jurisdiction shall be Lewis County in the State of Washington.

PATIENT CONSENT & SIGNATURE

______________________________________________
Sign Here (If Minor, Parent Must Sign) Date

CANCELLATION & NO SHOW POLICY

Medical Massage & Acupuncture requires 24 hour notice in advance if you are unable to keep your appointment. Since we set aside one hour for each appointment, it is only respectful of our time, as well as the time of others who wish to be seen, that you give adequate notice. We certainly understand that extenuating circumstances can arise over which you have no control. However, please be advised that we will charge $25.00 in the event that an appointment is missed/late cancellation. This is a charge for which your insurance company is not responsible. Therefore, it will be billed directly to you.

I have read and understand the above policy and agree to abide by it while being treated at Medical Massage & Acupuncture.

PATIENT CONSENT & SIGNATURE

______________________________________________
Sign Here (If minor, parent must sign) Date
**MEDICAL MASSAGE & ACUPUNCTURE P.S.**

**DEMOGRAPHIC INFORMATION**

Date: ____________________

Name: _______________________________________________________________________________

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<th>First</th>
<th>Middle Initial</th>
<th>Last</th>
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Date of Birth: ______________________ Age: ___________ Sex: Female/Male

SSN: _____________________________ Marital Status: Single/Married/Divorced/Separated/Widow

Mailing Address: ____________________________________________________________

City: ____________________________ State: _______________________ Zip: _____________

Physical Address: _______________________________________________________________

(If different then above)

Home Phone: _________________________ Cell Phone: _________________________________

Work Phone: _________________________ Email: _________________________________

Employer: ___________________________ Occupation: _______________________________

Employer Address: _______________________________________________________________

Spouse/Guardian Name: ___________________________________________________________

Phone: _____________________________ Cell: _________________________________

Spouse/Guardian Employer: _______________________________________________________

Spouse/Guardian Employers Phone: _________________________________

Emergency Contact: _____________________________________________________________

Relationship: _________________________ Phone: _________________________________

Family Physician: _______________________________________________________________

Phone: ______________________________

Referred By: ___________________________________________________________________
# HEALTH REPORT

## PREVIOUS HISTORY

<table>
<thead>
<tr>
<th>Please list injuries, falls or surgeries</th>
<th>Date</th>
<th>Treatment</th>
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## NAME 3 SYMPTOMS OR PROBLEM AREAS: (HEADACHES, PAIN, OR TENSION) PLEASE RATE INTENSITY ON A SCALE OF MILD, MODERATE, OR SEVER. HOW LONG HAS THIS OCCURRED?

<table>
<thead>
<tr>
<th>Symptom or Problem Area</th>
<th>Intensity</th>
<th>How Long?</th>
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ON FIGURES BELOW, MARK THE LOCATIONS OF THE SYMPTOMS. PLEASE LABEL IF PREVIOUS OR CURRENT.

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Name_________________________________________ Date of Birth_____________________

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