Informed Consent for Treatment and Care

1. CONSENT

I hereby voluntarily consent to be treated by Samantha Kadrmas, L.Ac, an acupuncturist licensed by the State of Maryland, and/or another licensed acupuncturist who is serving as backup for Samantha Kadrmas.

2. SERVICES TO BE PROVIDED

AcuWorks modalities attempt to treat body dysfunctions or diseases and attempt to make normal the body's physiological functions.

I understand that no guarantees concerning the use and effects of these treatments are given to me, and that I am free to refuse or discontinue treatment at any time.

Treatments may include and are not limited to:

Acupuncture (insertion of sterile, disposable needles or lancets into the skin)
Moxibustion (application of heat to the skin by the smoldering of mugwort herb on or near an acupuncture point)
Laser acupuncture (application of low-energy laser beam to acupuncture points)
Gua sha (rubbing the skin with a smooth object)
Cupping (application of glass cups to the skin along the meridians with a heat-created or suction-created vacuum)
Dermarolling (using a small roller on the skin)
Acupressure and bodywork
Nutritional, homeopathic and lifestyle recommendations
Herbal medicine

I understand that herbal medicine is a complex form of medicine using plant, animal or mineral products to be ingested orally or used topically on the skin. I am aware that the use of herbal medicine is not yet a common practice in the United States, and that herbs are not regulated by the FDA. While my practitioner will make every attempt to ensure the quality of the products she prescribes, I will not hold her responsible for the content of the formulas she recommends.

3. MEDICAL TREATMENT

I understand that it is my responsibility to inform my acupuncturist of all aspects of my health on the health history and medication forms, including any changes in my health since my last visit.

I am aware that if there is a worsening of my ailment or condition, or if a new ailment or condition appears, that I should consult my personal physician or any other licensed physician. None of the foregoing precludes the administration to me of conventional medical therapy by a licensed physician when in his or her discretion such therapy is deemed appropriate.

4. RISKS/POSSIBLE SIDE EFFECTS

AcuWorks modalities are generally recognized as safe treatments. I am aware that some risks are possible, as with any treatment. These could include, but are not limited to, brief pain or discomfort, small local bruising, slight bleeding, headache, tingling, dizziness, or burning from mugwort herb. Rare instances have been reported of fainting,

spontaneous miscarriage, infection, or pneumothorax (lung puncture). There may be brief and temporary aggravation of symptoms existing prior to treatment.

Any herbs or nutritional supplements suggested to me are considered safe at the doses prescribed, although as with any consumable, may be toxic in large doses. While not common, side effects can occur. Some examples include, but are not limited to, headaches, skin rashes, digestive upset, or allergic reactions. Although herbs have the potential to interact with pharmaceuticals, clinically significant interactions between most herbs and prescription drugs are rare or only potentially possible in theory. If there is an indication that that the effect of a drug is being altered by the simultaneous use of an herbal formula, I will report this directly to all health professionals involved.

5. PAYMENT

Payment will be at the time of service, unless otherwise prearranged. I have been informed of and agree to the fees for service

I am responsible to send my own claims for reimbursement to my insurance company. If I am a member of an HMO, PPO or health insurance company that does not reimburse for acupuncture, I have freely sought acupuncture services at my own expense and do not hold my HMO, PPO or health insurance company liable for payment.

6. MISSED APPOINTMENTS/LATE CANCELLATIONS

I understand that there will be a charge for missed appointments and appointments cancelled with less than 24 hours notice unless the cancellation results from an emergency (a sudden, unexpected situation or set of circumstances). I understand that insurance does not pay for missed appointments or late cancellations and that I will be personally responsible for the charges.

7. NOTICE OF PRIVACY PRACTICES

I have received a copy of the *Notice of Privacy Practices* for AcuWorks Inc. or I have been directed to it on the office website. I understand that my protected health information will be used and disclosed consistent with the policies in that document.
I understand that I may ask clarifying questions about the policies.

8. UNDERSTANDING/QUESTIONS

I have carefully read (or have had read to me) this consent and understand all the foregoing, including possible risks involved, and so am fully aware of what I am signing. I intend this consent form to cover the entire course of my treatment. I have felt free to ask any questions I have.

Signature (Client/Parent/Guardian)_______________________________________

Print Client's Name_________________________________Date______________