

PATIENT INFORMED CONSENT FOR ACUPUNCTURE AND/OR HERBS

I, _____, hereby voluntarily consent to be treated with acupuncture and/or Chinese Herbs, administered by HoliCare, LLC.. I understand that acupuncture is performed by the insertion of fine, pre-sterilized, disposable acupuncture needles (with or without the addition of electric current) through the skin, or the application of heat to the skin, or both, at certain points on the body, in an attempt to improve the body function and/or relieve pain.

I acknowledge that, although rare, certain side effects may result from acupuncture. These can include bruising, mild pain or discomfort, a feeling of weakness, fainting, nausea, and temporary aggravation of symptoms. These effects are unusual and of short duration.

I accept the fact that no guarantee is made concerning the use and effects of acupuncture or Chinese Herbs. I understand that I may stop treatment at any time.

I further understand that the evaluation given me is an energetic assessment of the acupuncture meridian network, and in no way purports to be, or replaces a western medical examination and diagnosis. In the course of the evaluation, there may be reference to the state of various "organ", such as heart, liver, spleen, kidneys, etc., which actually refers to energetic channels of the same name.

I acknowledge the fact that the practitioners of HoliCare, LLC, are not and do not profess to be a western-trained medical doctors and do not use or advise on the use of medically-prescribed pharmaceuticals or medical treatment, nor do the practitioners give any substances by injection.

I acknowledge that herbal products are not approved by Food and Drug Administration of USA (FDA).

I acknowledge that the practitioners of HoliCare, LLC. have completed a minimum of three years training in Acupuncture and Oriental Medicine is National Board Certified (NCCAOM) and a Licensed Acupuncturist (L.Ac) in the State of Illinois.

If clinic data is gathered it will be without names and may be used for statistical data and research. According to federal policy, we need you written consent for the following:

Do we have your permission to make appointment confirmation calls? Yes or No

If yes, what number(s) shall we call?

Home _____ May we leave a message? _____

Cell _____ May we leave a message? _____

Work _____ May we leave a message? _____

Signature: _____ Date: _____ Witnessed by _____

Patient or Guardian

Practitioner