Integrative Living Well **Consent to Treat** **Cortney Singleton, AP 3568**

Name: ____ Date:____________________

Home Address: ____

PhoneNumber:__________________________Email:_____________________________

Age: __________ Date of Birth: ________________________ Gender: □ Male □ Female

Height: __________ Weight: __________ Emergency Contact: ___________________________

Relationship: ________________ Primary Contact Number: _____________________

How did you hear about us? ____

Injectable Requested: **B-12** ____ **Lipotriopic** ____ **Traumeel** ____ **Zeel** _____ **Combo** _____

Do any of the following conditions apply? Please circle.

Pregnant/ Pacemaker/ HIV/ Hepatitis/ Blood Transfusion/ High Blood Pressure/ Infectious Disease/ Cancer/ Asthma/ Emotional Disorder/ Seizures/ Other: ______________________________

Current Medications (dosage) and Supplements:

____

____

Chief Complaint/ Reason For Visit:

____

____

Please circle to describe pain: Fixed/ Moves/ Radiates/ Sharp/ Dull/ Swelling/ Stiffness/ Burning/ Spasm/

Other: ______________________________ Pain Level 1-10 (extreme): _______________

Have you had acupuncture before? ________ Condition? ___________ Was it affective? __________

Energy Level? Please circle: High/ Medium/ Low

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Jennifer Cortney Singleton, AP. I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese Massage),

Chinese Herbal Medicine, nutritional counseling, acupoint injection therapy, vitamin B-12 Injectables and homeopathic remedies. 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 be an unpleasant smell and taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant side effects associated with the consumption of the 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 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 only sterile, single use, disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping and heat/light therapy. I understand that while this document describes the 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 the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant. I will notify a clinical staff member who is caring for me if I have a severe bleeding disorder, have a history of seizures, or a pace maker PRIOR to any treatment. I do not expect Jennifer Cortney Singleton, AP or the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and 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 on the facts then known is in my best interest. I understand the 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 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 form to cover the entire course of treatment for my present condition(s) for which I seek treatment. I understand that there is neither an implied nor stated guarantee of success or effectiveness of treatment. I hereby authorize Jennifer Cortney Singleton, AP. to release any information regarding my condition to the referring physician(if any) and/or to my insurance for the processing of any claim. I also authorize Jennifer Cortney Singleton, AP to obtain my medical records from other physicians or medical centers.NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PatientSignature:____ Date:_______________

Patient Printed Name: ____

Legal Guardian Name and Signature:____