



Flowing River Clinic

COMPLEMENTARY ALTERNATIVE MEDICINE

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INFORMED CONSENT TO TREATMENT

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, indirect moxibustion, cupping, infra-red heat therapy, moist heat packs, paraffin dip, electrical stimulation, Chinese Herbal Medicine, therapeutic massage, Tui Na, and nutritional counseling. I understand that the homeopathic method of treatment used in this practice is limited to the prescribing of oral homeopathic remedies.

I understand that acupuncture, indirect moxibustion, cupping, infra-red heat therapy, moist heat packs, paraffin dip, electrical stimulation, Chinese Herbal Medicine, therapeutic massage, Tui Na, nutritional counseling, and homeopathy are all safe methods of treatment. Potential risks of acupuncture include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting, nerve damage, spontaneous miscarriage, and organ puncture. Infection is possible, although this practice uses alcohol and sterile single-use disposable needles and maintains a safe and clean environment. Potential risks of indirect moxibustion, infra-red heat therapy, moist heat packs, and paraffin dip are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a potential side effect of cupping.

I understand that the homeopathic remedies, Chinese herbal formulas, and nutritional supplements recommended to me by my practitioner are safe in the recommended doses. Large doses of homeopathic remedies, Chinese herbal formulas and nutritional supplements taken without my practitioner's recommendation may be toxic, and some herbal formulas and nutritional supplements are inappropriate during pregnancy. Some possible side effects of Chinese herbal formulas are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

I understand that the homeopathic remedies, Chinese herbal formulas, and nutritional supplements need to be consumed according to the instructions provided to me orally and in writing by my practitioner. I understand that I must stop taking all herbal formulas, nutritional supplements, and homeopathic remedies and notify my practitioner immediately upon experiencing any discomfort or adverse reactions.

I will notify my practitioner should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid acupuncture points and herbal formulas that could induce miscarriage. Otherwise, Traditional Chinese Medicine treatments can be very beneficial in the pregnancy and birthing process.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I understand that my practitioner may review my medical records and lab reports, but all my records will be kept confidential. If it becomes necessary to share my health information, this will be handled in accordance with the stipulations detailed in the HIPAA Notice of Privacy Practices document that has been provided to me, and of which I have acknowledged receipt.

I hereby release Connie Herrick, L.Ac., Dipl. O.M., Di. Hom. and Rhoda Climenhaga, L.Ac. and the Flowing River Clinic from all liability that may occur in connection with the abovementioned procedures, except for failure to perform the procedures with appropriate medical care and/or failure to perform procedures as outlined in the California legal scope of practice. I understand that I am free to withdraw my consent and discontinue participation at any time.

I have read, or have had read to me, the above Informed Consent to Treatment. I have also had an opportunity to ask questions about its content, and by voluntarily signing this form, I acknowledge any inherent treatment risks, give my consent for treatment, and will issue payment for all healthcare received at this practice. 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.

Date

Print Patient Name (or Representative)

Signature of Patient (or Representative)