Informed Consent to Receive Chinese Medical Treatment

I understand that the treatment I receive is performed by a State licensed, Board certified acupuncturist. I understand the practices used meet the standards for ensuring sterility set by the Centers for Disease Control and Prevention (CDC) and conform to the guidelines for the Clean Needle Technique (CNT) established for acupuncturists by the National Commission for the certification of Acupuncturists and Oriental Medicine (NCCAOM).

I understand that acupuncturists do not do Western medical (biomedical) diagnosis and that I will not receive such diagnosis.

| hereby authorize the practitioner Victoria Sous, LAc to perform diagnosis and treatment according to the professional standards of Oriental Medicine and her own professional judgement. This authority shall extend to remedying any unforeseen conditions or reactions to treatment procedures. I understand that my treatment may include a variety of Chinese medical modalities such as acupuncture, moxibustion, cupping, electrical stimulation, acupressure, tui na and gua sha based on chinese medical principles. I understand that I may receive a recommendation for dietary therapy and that such recommendation does not constitute a prescription for dietary therapy. If I receive tui na, I understand that tui na is a meridian based manipulative therapy meant to be adjunct to acupuncture and does not constitute a massage.

I have been informed that possible side effects of Chinese medical treatment are rare but may include: transient bruising, bleeding, skin irritation, mild pain in the treated area, muscle weakness and soreness, brief generalized fatigue or nausea, sensations of heat or cold, tingling or numbness, brief lightheadedness or fainting, broken needles, temporary worsening of some symptoms and risks of infection and pneumothorax. Moxibustion may cause burns. There may also be unknown side effects.

I understand that no promises or guarantees can be made regarding the outcome of treatment and that reasonable efforts will be made to give me information so that I might make educated decisions regarding the duration and appropriateness of continued care. All treatments are done on the basis of informed consent and I understand that as a patient I have the right to ask for the immediate termination of treatment at any time.

I understand and agree that I am ultimately responsible for the balance on my account and that all fees are payable at the time that service is received. I set forth that all information provided is accurate to the best of my knowledge.

I have/have not (circle one) been examined by a licensed physician or other licensed health care provider with regard to my illness or injury and have provided information from this examination to my practitioner.

[] I have read and understand my provided copy of the Notice of Privacy Practices and agree to its terms.

Patient Name (print) _____

Patient Signature Date _____

Practitioner Name (print) _____

Practitioner Signature Date _____

SMS Text Appointment Reminder

I agree to allow Healing Paradise Acupuncture, LLC, as the practitioner Victoria Sous, Lac to send SMS text appointment reminders to my mobile phone 1 day before my scheduled appointment. I understand that standard data and message rates may apply to this SMS service. If I choose to cancel this service, I will contact Healing Paradise Acupuncture via phone or email to cancel these reminders. Lastly I understand that this agreement is not an agreement of purchasing a good or service.

Patient Signature _____

Mobile Number _____