CONSENT TO AURICULAR ACUPUNCTURE TREATMENT

I, _____, understand that Auricular Acupuncture Treatment (as defined below) is provided by Maryland Licensed and credentialed Acupuncturists as defined ("Clinicians"). In this case, my medical history, treatment plan, and progress are decided by the clinicians for appropriateness and effectiveness. I understand that this agreement covers the Clinician and any other Clinicians associated with relief effort who now or in the future treat me.

Auricular Acupuncture Treatment: I understand that Clinicians will perform a standardized auricular acupuncture protocol for behavioral health, mental health, and disaster and emotional trauma. Treatment consists of insertion of five special sterilized acupuncture needles in points on the ear.

Potential Risks: I understand that, while not common, side effects can potentially occur from the Auricular Acupuncture Treatment. Some examples include, but are not limited to: pain, discomfort, local bruising, slight bleeding, fainting, headaches, rashes, and temporary aggravation of symptoms existing prior to treatment. Less common side effects include: spontaneous miscarriage, infection, and nerve damage.

Medical Treatment: I understand that it is my responsibility to inform my Clinician of all aspects of my health on the attached Limited Health History form, including any changes in my health status since my last Auricular Acupuncture Treatment. If there is a worsening of an ailment or condition, or if a new ailment or condition arises, I should consult a licensed physician. I also understand that if I am currently under a physician's care, I should continue as long as my physician and I deem it necessary. I further understand the Clinicians do not recommend altering medications or other therapies without first consulting my personal physician or health care provider.

Privacy: I have received the Notice of Privacy Practices.

Voluntary: I hereby request and consent to the performance of the Auricular Acupuncture Treatment on me. I have not been guaranteed any specific outcomes concerning the uses and effects of this treatment. I understand that I am free to discontinue treatment at any time. I voluntarily assume all risks inherent in the nature of the Auricular Acupuncture Treatment. I waive all claims, costs, liabilities, expenses and judgments against Clinicians and release Clinicians and Ellicott City Wellness Center from all claims, costs, liabilities, expenses, and judgments arising out of the Auricular Acupuncture Treatment.

By voluntarily signing below, I confirm that I have read, or have had read to me, and understand the above Consent to Auricular Acupuncture Treatment, have been told about and understand the risks of the Auricular Acupuncture Treatment, and have had an opportunity to ask questions. 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.

Client Printed Name **Client Signature** (or Guardian/Personal Representative) **Date**

LIMITED HEALTH HISTORY

Name: _____

M: _____ **F**: _____ **Date of Birth**: _____ **Phone**: _____

Address: _____

Emergency Contact: _____ **Phone**: _____

Are you taking drugs prescribed by a doctor? No : _____
Yes:
_____

If yes, which ones? _____

Are you taking over-the-counter drugs or herbs? No : _____
Yes:
_____

If yes, which ones? _____

Are you taking any blood thinners, such as Coumadin (warfarin)? No : _____
Yes:
_____

Do you have a history of any of the following conditions?

H L H H
D F S H

For women: Are you pregnant? Yes: No : _____
_____

Are there any other health concerns you wish to discuss or feel your Clinician should be aware of?

No: _____ Yes: _____

Client Printed Name **Client Signature** (or Guardian/Personal Representative) **Date**

For Office Use Only:

For Office Use Only:

Treatment Plan:

Important Treatment Notes/Observations:

NADA Protocol: _____

Licensed Acupuncturist Name: **L.AC. Signature**
Date