# Voluntary Consent Form

I voluntarily consent to be treated with acupuncture by a licensed acupuncturist employed by Earley Wellness Group The acupuncturist is licensed in the District of Columbia. I understand that methods of treatment may include, and are not limited to acupuncture, moxibustion, cupping, electrical stimulation, gua sha, Chinese herbal medicine, postural assessment, exercise and nutritional counseling.

I understand that acupuncture is performed by the insertion of needles through the skin, or by application of heat to the skin, or both, at certain points on or near the surface of the body in an attempt to treat body dysfunctions or diseases, to modify or prevent perception of pain, and to normalize physiological functions.

I understand that acupuncture is a generally safe method of treatment, and may have some side effects including, dizziness or fainting, and numbness, bruising, or tingling near the needling sites that may last a few days. Burns and/or scarring are potential risks of moxibustion and infrared heat lamps. Bruising may result from cupping or gua sha. I understand that rare and unusual risks of acupuncture include infection, nerve damage, organ puncture, including lung puncture (pneumothorax). I understand that this clinic uses sterile disposable needles and maintains a clean needle protocol and safe environment.

I understand that Chinese herbs (that are from plant, animal and mineral sources) may be recommended and are traditionally considered safe in the practice of Chinese Medicine. I understand that Chinese herbs may have an unpleasant taste or smell and I will immediately notify the practitioner(s) of any unanticipated or unpleasant effects associated with the consumption of Chinese herbs. Some possible side effects of taking Chinese herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

I will notify the practitioner(s) if I am or become pregnant. I am aware that if there is a worsening of my ailment or condition, that I should immediately notify the practitioner(s) and/or consult a licensed physician.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. While I do not expect the practitioner(s) to anticipate and explain all possible risks and complications of treatment, I will rely on the practitioner(s) to exercise judgment based on my best interest. I understand that results are not guaranteed.

I understand the practitioner(s) 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 and for any future condition(s) for which I seek treatment.

## Notice of Privacy Practices for Earley Wellness Group

The Health Insurance Portability and Accountability Act (HIPAA) requires that health care professionals give their clients a Notice of Privacy Practices and that clients sign in acknowledgement that they received the notice.

***Your health information will be routinely used for treatment, payment, and quality monitoring, and your consent, or the opportunity to agree or object, is not required in the following instances:***

- Information obtained by your practitioner will be entered in your record and used to plan the course of treatment.
- Your record will be used to receive payment for services rendered by the practitioner(s) at Earley Wellness Group.
- This office will use your health information to assess the care you received and compare your treatment outcomes to others. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.

***In addition, the following disclosures are required by law and do not require your consent:***

- This office is required by law to disclose heath information to the Food and Drug Administration **(**FDA) related to any adverse effects of food, supplements, products, and product defects for surveillance to enable product recalls, repairs, or replacements.
- This office will release information to the extent authorized by law in matters of worker's compensation.
- This office is required by law to disclose health information in response to a valid subpoena for law enforcement purposes, as required under state or federal law.
- In the event that a member of this office believes in good faith that one or more patients, workers, or the general public are endangered due to suspect or clinical standards, provisions of federal law permit the disclosure of your health information to appropriate health oversight agencies, public health authorities, or attorneys.
- This office will disclose your health information in cases of domestic violence.

***The following are considered routine uses and disclosures for which specific authorization will not be requested. You have the right to request restrictions on these uses. Otherwise, this office will request your authorization only when disclosure of personal health information is necessary to parties other than those referenced here.***

- Using best judgment, a family member, close personal friend identified by you, personal representative, or other persons responsible for your care may be notified or given information about your care to assist them in enhancing your well-being or to confirm your whereabouts.
- This office may send information to you about health-related issues that you may find useful. Only your name and address will be used.

I acknowledge may voluntarily consent to treatment, and that I have received and understand this Notice of Privacy Practices.

Signature: _____Date_____