Informed Consent Form For Acupuncture & Oriental Medicine

I, the undersigned, hereby authorize Dr. Diana Lee, ND LAc to perform the following procedures:
· **Acupuncture:** The insertion of pre-sterilized, disposable needles through the skin into the underlying tissues at specific points on the surface of the body.
· **Acupressure, massage, and manual therapy:** The use of Traditional Chinese medical massage and therapeutic bodywork.
· **Infrared heat therapy:** Applying heat generated by an infrared lamp over a specific area.
· **Moxabustion:** Heated moxa stick used over specific areas of the body.
· **Cupping:** Glass or plastic cups are placed on the skin with a vacuum created by heat or suction.
· **Liniments, Essential Oils, Plasters:** Herbal or medicinal formulas applied topically to the skin.
· **Electroacupuncture:** Using very small amounts of electricity to stimulate specific acupuncture points.

I recognize the potential benefits and risks of these procedures as described below:
· **Potential Benefits:** Drugless relief of presenting symptoms and improved balance of body energies that may lead to prevention, improvement or elimination of the presenting problem.
· **Potential Risks:** Discomfort, pain, bruising, blistering, bleeding, infection at the site of the procedure, temporary discoloration of the skin, possible aggravation of symptoms existing prior to the acupuncture treatment.

Patients with bleeding disorders, pacemakers or surgical hardware should inform the practitioner prior to receiving treatment.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Lee regarding cure or improvement of my condition. I hereby release Dr. Lee from any and all liability, which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw this consent and to discontinue participation in these procedures at any time.

Signature of Patient Date

Signature of Parent or Legal Guardian Date

Notice of Privacy Practices

I have received notice of privacy practices. I consent to the use of my personal health information for the purposes of treatment, payment and clinic healthcare operations. I am aware of the detailed description of the privacy of this clinic is available upon request and the a copy of the detailed privacy policy is available on www.seattlenaturopathiccenter.com

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Initials + Date

Payment

I agree to pay for any fees for services, costs of supplements and remedies, costs of laboratory tests, or other costs or fees that are not covered by my insurance plan.

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Initials + Date