

Sarah E. O’Leary, M.Ac., L.Ac., Seeds Center for Whole Health

Information and Consent to Services

Treatment Policy

I hereby *voluntarily* consent to acupuncture treatments and understand the following:

- That the attending practitioner may administer any treatment or perform any service deemed advisable in my care and treatment.
- That I will have the opportunity to discuss therapeutic courses with the practitioner to my satisfaction;
- That I have the right to consent to or refuse any proposed treatment or course of treatment.
- That each person is unique and has ultimate responsibility for his or her own healthcare. I acknowledge that I have not received any guarantees or promises as to the results or success that will be obtained from acupuncture and/or moxibustion.

Services Provided

I understand that acupuncture serves individuals with a wide range of complaints including both acute and chronic healthcare issues. I understand that I will be treated with the insertion of thin, sterilized needles and/or with moxibustion, which is an application of heat to the skin.

Risks/Possible Side Effects/Healing Response

I understand that acupuncture may result in certain side effects, including local bruising, slight bleeding, fainting (very rarely), temporary pain and discomfort, and temporary aggravation of symptoms existing prior to treatment.

Infectious Disease Prevention

I understand that infectious diseases are carried through the air, through physical contact, and through body fluids. I understand that my practitioner follows universally prescribed precautions and procedures (such as clean needle technique, clean room procedures, and hand washing) to prevent the spread of infectious disease.

I have read this form entirely. I have also received the Notice of Privacy Practices and the Practices Regarding Disclosure of Health Information. I am under no obligation to sign and do so of my own volition in order to pursue treatment.

Patient Name: _____
(print)

Patient Signature: _____

Signature of parent or guardian if patient is minor:

Patient Responsibilities

I understand it is my responsibility as a patient to inform my practitioner about all aspects of my health and that, as treatment progresses, to inform my practitioner of changes that occur. If I experience any pain, discomfort or possible adverse reactions or side effects, it is my responsibility to immediately notify my practitioner.

Medical Treatment

I recognize that my practitioner is not a substitute for a medical doctor and will not suggest that I discontinue medical treatment. I am free to consult a medical doctor or any other licensed practitioner at any time. I understand if there is an emergency, or a worsening of my health condition, or if a new ailment or condition arises, that I should consult a licensed physician.

Confidentiality and Exceptions

I acknowledge that I was informed of Sarah O’Leary’s privacy practices which describes the practitioner’s policy of respecting patients’ right to privacy and the exceptions that require disclosure of confidential information.

License and/or Certification

I understand that Sarah O’Leary, my practitioner, has studied extensively the field of Acupuncture and Moxibustion and has earned a Master’s Degree from the TAI-SOPHIA INSTITUTE, a nationally respected institution in the field. She has also obtained her license to practice from the Maryland State Board of Acupuncture. I have the right to ask for copies of those licenses and certifications.

Fees and Charges

I have been informed of the fees of service and I understand that payment is due when the services are rendered.

I understand that if I need to cancel an appointment, I will notify my practitioner at least 24 hours in advance, or I am liable for a fee.

Date: _____

Date: _____