Dr. Jessica B. Lipham, D.O.M., Lac

INFORMED CONSENT TO TREAT

I, _____, hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Dr. Jessica B. Lipham.

I understand that methods of treatment may include, but are not limited to; acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, nutritional counseling, botanical medicine, cosmetic acupuncture, JMT, homeopathy, gua sha, and acupuncture injection therapy. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs, or any nutritional/botanical supplement. I have been informed that acupuncture and acupuncture injection therapy are generally safe methods of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping and injection therapy. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment at all times.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy.

I agree to inform my practitioner immediately if:

- I am pregnant, as many modalities will be contraindicated
- If I have any changes to my prescriptive medications
- If I experience any negative side effects

I understand the clinical 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.

I consent to communication regarding: (please initial)

____Appointment Dates and Times

____Brief Messages Regarding Care

____**None** of the Above

I consent to communication by:

____Text

____Email

____Voicemail

____**All** of the Above

Other request regarding communication_____

By voluntarily signing below, I show that I have read or have had read to me, the above consent to treatment (pages 1 and 2), have been told about the risks and benefits of acupuncture and other procedures, I have selected my preferred methods of communication 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.

_____

Print Patient Name

_____

Patient/Guardian Signature Date