Lotus Acupuncture & Fertility Clinic

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CONSENT FORM

This is a medical consent form for the **Lotus Acupuncture & Fertility Clinic**. Please read the following statements and sign it once you feel you understand all of them.

Primary Care Providers

I understand that acupuncturists practicing in Washington state are not primary care providers. I understand that this clinic requires that all patients have a primary care provider as part of a conjunctive care program and that all patients provide medical records from his/her primary care providers upon request.

Procedures and Products that May Apply to Treatment

Acupuncture, Electro-acupuncture, Acupressure, Cupping, Guasha, Tuina (Chinese massage), Moxibustion, Chinese Herbs

Potential Risks and Side Effects of Acupuncture and Chinese Medical Procedures

Local bruising	Minor bleeding
Needle sickness	Bending or breaking of needles
Pain or discomfort	Burning or scarring
Abdominal pain or discomfort	Changes in bowel movement

PARQ (Procedures, Alternatives, Risks & Questions)

I have gotten the explanation of procedures and risks, and have been asked if alternatives to care are given (i.e. chiropractic, massage) and questions and concerns of mine related to the treatment here.

Record Release Authorization

I understand that I am responsible for my bill.
I authorize the use of this form for all of my insurance submissions.
I authorize release of information to all of my insurance companies.
I permit a copy of this authorization to be used in place of the original.
I direct my previous health care providers to release medical records to this clinic.
I authorize the staff of **Lotus Acupuncture & Fertility Clinic** to act as my agent to obtain payment from my insurance companies.

I consent to treatment with acupuncture and Chinese medicine at this clinic.

Patient Signature _____ Date _____
Patient Printed Name _____ Date of Birth _____

Consent to Treat a Minor Child

I authorize the acupuncturist and/or whomever they designate as assistants to administer acupuncture care as deemed necessary to my _____ (relationship).
Patient's Name _____
Parent or Guardian's Signature _____ Date _____