



Informed Consent

We believe that patients are our partners in their care and wellness. Please ask questions about your treatment so that you may continue to make informed, responsible decisions regarding your health care.

Acupuncture: I understand that acupuncture is performed by the insertion of sterile, disposable needles and may include the application of heat, manual, or electrical stimulation to certain points on the body. Although rare, certain side effects may include but are not limited to: local bruising, minor bleeding, lightheadedness, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Moxibustion: I understand that if I receive moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended as part of my treatment. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances including, but not limited to: changes in bowel movement, an unpleasant taste or smell, nausea, vomiting, headache, or rashes. **Should I experience any problems associated with these substances, I will immediately suspend taking them and call Wildsong Wellness LLC as soon as possible.**

Acupressure/Tui-Na Massage/Cupping/Heat Lamps: I understand that acupressure, Tui-Na massage, cupping, and/or heat lamps may be used as part of my treatment. I am aware that certain side effects may result from these treatments which can include, but are not limited to: sore muscles or aches, bruising or redness, or burns. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that electro-acupuncture administered with or without needles may be used during treatment. I am aware that certain side effects may result including, but not limited to: electrical shock, pain, or discomfort. I understand that I may refuse this treatment.

I understand the acupuncturist may review my patient record and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that all payments, including co-pays, are due at the time of service. Fees are discounted for payment at time of service.

I understand that if I am unable to keep my appointment, I will give 24 hours' notice. I understand that **if I cancel with less than 24 hours' notice** or do not show for the appointment, **I will be charged a \$35.00 fee** which will be my responsibility to pay before my next visit.

By signing below, I voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist. I understand that acupuncturists practicing in the state of WI are not primary care providers and that regular primary care by a licensed physician is strongly recommended.

Signature

Date

Printed Name

Date of Birth