Wholistic Family Healthcare

301-495-0303

Infants • Children • Adults

Simeon Pollock, *Licensed Acupuncturist,*
Certified Massage Therapist

PATIENT ADVISORY TO CONSULT A PHYSICIAN

Wholistic Family Healthcare, Simeon Pollock, C.M.T., L.Ac. is committed to your health and well being. I believe that while Oriental Medicine and Massage Therapy have a great deal to offer as a health care system, they cannot totally replace the resources available through biomedical physicians. Consequently, I recommend that you consult a physician regarding any condition or conditions for which you are seeking acupuncture treatment.

WE THE UNDERSIGNED, DO AFFIRM THAT ______________________________ (patient) HAS BEEN ADVISED BY SIMEON POLLOCK, C.M.T., L.Ac. TO CONSULT A PHYSICIAN REGARDING THE CONDITION OR CONDITIONS FOR WHICH SUCH PATIENT SEEKS ACUPUNCTURE and/or MASSAGE TREATMENT.

______________________________ ____________

Patient Signature Date

______________________________ ____________

Licensed Acupuncturist/Massage therapist Signature Date

INFORMED CONSENT TO ACUPUNTURE/MASSAGE TREATMENT

I consent to acupuncture and/or massage treatment and other procedures associated with the practice of Chinese medicine provided by members of Wholistic Family Healthcare, Simeon Pollock, C.M.T., L.Ac. I have discussed the nature and the purpose of my treatment with the clinical staff named below.

I understand that the methods of treatment may include but are not limited to: acupuncture, moxibustion, cupping, electrical stimulation, AMMA Chinese massage, Swedish (European) massage.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last for a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another risk, although this clinic uses sterile, disposable needles and maintains a clean and safe environment. Burns and scarring are potential risks of moxibustion. I understand that while this document describes the major risks of the treatment, other side effects or risks may occur.

The herbs and nutritional supplements (which are from plants, animal, and mineral sources) which may be 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 not be appropriate during pregnancy. Some possible side effects are nausea, gas, stomachache, vomiting, diarrhea, rashes, hives, and tingling of the tongue.

I understand that the herbs need to be prepared and the tea consumed according tho the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the Clinical Staff of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I will notify the clinical staff to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on the clinical staff to exercise judgement during the course of treatment, based upon the facts known to them, is in my best interests.

I understand the clinical and administrative staff may review my medical records and lab reports and that portions of my records may be used for teaching or research purposes, however my name and identifying information will not be disclosed. Otherwise all of my records will be kept confidential and will not be released to any party without my written consent.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, 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.

To be completed by patient (or patient's representative if the patient is a minor or is physically or legally incapacitated).

______________________________ ______________________________

Date Consent Completed Print Name of Clinical Staff

______________________________ ______________________________

Print Name of Patient or Representative Signature of Clinical Staff

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Signature of Patient or Representative