Enjoy Acupuncture P.C

16 E 40th St 2nd Floor NY NY 10016

INFORMED CONSENT TO TREATMENT

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 the patient named below for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or Serving as back up for the acupuncturist named below, including those working at the clinic or office listed below or any: other office or clinic, whether signatories to this form or not.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have side effects, including but not limited to bruising, numbness or tingling near the needling sites that may last 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 possible risk, although the clinic uses sterile, disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I understand that any herb recommendations made by the clinicians are done so in an unregulated environment in New York State and the practice of herbs is not specifically identified within scope of practice for a licensed acupuncturist in New York State. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that are recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses.

HIPAA Compliance

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

Print Patient Name ***Signature of Patient/Legal Guardian*** **Date**

David Solomon Kim

Nam e of P rac ti tion er ***Si gn atu r e of Pr ac ti tio n er*** **Date**