ACUPUNCTURE365 PLLC
HEMDA RAHMANI Dipl. L,A,c
New York Board Certified Acupuncturist.

1. PATIENT ADVISORY TO CONSULT A PHYSICIAN

Our acupuncture group I committed to your health and well-being. We believe that while Oriental Medicine and Acupuncture has a great deal to offer as a health care system. It cannot totally replace the resources available through biomedical physicians. Consequently, we recommend that you consult a licensed physician regarding any condition or conditions for which you are seeking acupuncture treatment. To comply with article 160, Section 8211.1 (b) of NYS Education law, we request that you read and sign the following statement.

WE, THUNDESIGNED DO AFFIRM THAT _____ **(patient)**

HAS BEEN ADVISED BY (*licensed acupuncturists*) *Hemda Rahmani* TO CONSULT A PHYSICIAN REGARDING THE CONDITION OR CONTIONS FOR WHICH SUCH PATIENT SEEKS ACUPUNCTURE TREATMENT

Patient Signature _____ Date _____
Licensed acupuncturist_____ Date_____

2. INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to acupuncture to acupuncture treatments and other procedures associated with the practice of Traditional Oriental Medicine provided by ACUPUNCTURE365 (licensed acupuncturist). I have discussed the nature and purposes of my treatment with the member of staff, named below;

I understand that method of treatment may include, but are not limited to acupuncture, Moxibustion, Cupping, Electrical Stimulation, Asian body work (TU- NA) Modalities, and Chinese or western Herbal Medicine.
I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness r 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 site uses sterile, disposable needles and maintain a clean and safe environment. Burns and /or scarring are a potential risk of Moxibustion. 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) 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 may be inappropriate during pregnancy. Some possible side effects of taking herbs 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 to the instruction provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of our staff of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I will notify the clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complication of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thins at the time, based upon facts known to them, in my best interest.

I understand the clinical and administrative staff may review my medical records and lab reports and that portion of my record and lab reports and those 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 withouy 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 cove 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.

Print name _____ Patient Signature ---------- Date

Licensed Acupuncturist: ***Hemda Rahmani*** Signature _____ Date