神 Julie Lawson Acupuncture

INFORMED CONSENT

Print Name ..... Date .....

I hereby give my consent to receive acupuncture treatment.

I understand that:

- Although acupuncture is known to be beneficial for a wide range of acute and chronic conditions, there are no guaranteed outcomes.
- Acupuncture is not a substitute for regular consultation with or treatment prescribed by my medical doctor.
- Acupuncture treatment will consist of fine, sterile, disposable needles being inserted into my body at specific points and, where appropriate, the use of moxibustion.
- Acupuncture is a safe method of treatment and there is the possibility of temporary complications which include, but are not limited to, minor bleeding or bruising, minor pain or soreness, nausea, weakness, fatigue, fainting, or aggravation of existing symptoms for a short time. If there are any specific risks that apply to my case, my practitioner will discuss these with me.
- My practitioner will, on an ongoing basis, clearly inform me of the nature and purpose of the proposed treatment, which I can refuse at any time.
- All questions regarding treatment are welcome and will be answered as fully as possible.
- Information shared during acupuncture sessions and my treatment records will be kept confidential and will not be released without my written consent.
- All treatment will be conducted by a trained and experienced practitioner, registered with the CTCMPAO.

I hereby request and give my consent to receive acupuncture treatment. I intend this consent to apply to the entire course of my treatment for both present and future conditions for which I seek treatment. I have had an opportunity to ask questions about this form's content. By signing below I agree to acupuncture procedures deemed clinically appropriate by my treating practitioner, based upon my best interests.

Signature ..... Date .....

Payment
Payment (cash or cheque) is made at the time of treatment unless prior arrangements have been agreed to with the practitioner.

Cancellation
Except in cases of emergency, 24 hours notice of cancellation is required. If you are unable to provide sufficient notice and/or we are unable to fill your slot, full fee will be charged.

I have read and understand both Payment and Cancellation policies:

Signature ..... Date .....

Ridgeway Wellness,
355 Ridge Road N, Ridgeway ON
(905) 380 5497
julaws@gmail.com

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"Circle of Care"

Print Name ..... **Date** ..... **D.O.B.** .....

PRIMARY PHYSICIAN

Name:.....

Address.....

.....

Phone/email .....

OTHER HEALTH CARE PROFESSIONALS
(Physiotherapist, Osteopath, Therapeutic Massage, Psychotherapist, Homoeopath etc)
Please list all with whom you are currently in treatment.

NAME:..... **NAME:**.....

Profession..... **Profession**.....

Address..... **Address**.....

Phone/email ..... **Phone/email** .....

NAME:..... **NAME:**.....

Profession..... **Profession**.....

Address..... **Address**.....

Phone/email ..... **Phone/email** .....

NEXT OF KIN

Name:.....**Relationship**.....

Address.....

.....

Phone/email .....

I hereby give my consent to information being shared with other health professionals with whom I am in treatment.

Signature ..... **Date** .....

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