**Naturopathic Informed Consent to Treat**

This document provides important information regarding the services being provided and should be carefully reviewed. Please ask any questions you have regarding services before signing this document.

**Consent**: I hereby request and consent to the performance of naturopathic treatments and/or other naturopathic procedures, including various modes of physical therapy and diagnostic procedures, on me (or on the patient named below, for whom I am legally responsible) by Dr. Stacie Han, ND, LAc, or a licensed Naturopathic Doctor in the state of California, who now or in the future may treat me while employed by, working or associated with or serving as a back-up for the Naturopathic Doctor named above, including those working at the clinic or office listed below or any other office or clinic whether signatories to this form or not.

**Type of care:** I have had an opportunity to discuss with the Naturopathic Doctor named above and/or with other office or clinic personnel the nature and purpose of naturopathic care and procedures.

I understand that this office utilizes many forms of diagnosis and therapy including but not limited to:

***Physical exam:*** e.g. general, musculoskeletal, cardiovascular, gynecological, abdominal, respiratory, neurological, urological.

***Medicinal use of nutrition:*** therapeutic nutrition, nutritional supplementation.

***Botanical medicine:*** botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters or suppositories.

***Homeopathic medicine*:** the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body’s healing responses.

***Lifestyle counseling and hygiene:*** diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.

## *Psychological counseling*

***Soft tissue manipulation:*** massage, muscle energy stretching, craniosacral balancing.

***Contraception and hormone replacement therapies***

***Intramuscular and Subcutaneous injections:*** nutritional supplementation, therapeutic nutrition, pain management, joint care

***Oral chelation therapy***

**No Guarantee:** I understand that results are not guaranteed.

**Recital of Risks:** I understand and am informed that, in the practice of medicine, there is some degree of risk to treatment. Within the general healthcare setting, the possible outcomes of these practices range from minor to fatal.

**I understand that some herbs and supplements may be inappropriate during pregnancy, and I will notify the doctor if I am or become pregnant.**

I will inform the doctor if I experience any gastrointestinal upset (nausea, gas, stomach ache, vomiting), allergic reactions (hives, rashes, tingling of the tongue, difficulty breathing, headache), or any unanticipated or unpleasant effects associated with the herbs, supplements or other treatment prescribed by the doctor. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

**Agreement and Continuous Effect:** I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

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*Signature of Patient or Patient Representative* *Date*  *Indicate relationship if signing for patient*

**Acupuncture Informed Consent to Treat**

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of Stacie Han, LAc on me (or on the patient name below, for whom I am legally responsible) by Stacie Han, LAc 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 Stacie Han including those working at the clinic or office listed below or by other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), use ot TDP lamp (infrared heating lamp), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to 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 herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. 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.

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) that have been 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 be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect 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 judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

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

By voluntarily signing below, I show that I have read, or have had read to me, the above 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.

Patient signature (Or Patient Representative – indicate relationship if signing for patient)

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Date