



MAUREEN GOSS ACUPUNCTURE

ADVISORY TO CONSULT PHYSICIAN

While Oriental Medicine has a great deal to offer as a health care system, it cannot replace the resources available through medical physicians. It is recommended that you consult a physician regarding any conditions for which you are seeking acupuncture treatment(s).

I, (print name) _____ have been advised by Maureen Goss, L.Ac. to consult a physician regarding the conditions, for which I seek acupuncture treatment(s).

Signature of patient or patient representative

Date

Signature of Practitioner

Date

CANCELLATION POLICY

I agree to pay the full price of a session if I do not comply with notifying Maureen Goss within 24 hours before my scheduled appointment time.

Signature of patient

Date

INFORMED CONSENT

I consent to acupuncture treatments and related procedures, associated with Oriental Medicine, by Maureen Goss, L.Ac. I have discussed the nature and purpose of my treatment with her and I understand that the methods of treatment may include but are not limited to acupuncture, moxibustion, cupping, gua sha and electrical stimulation. 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 needle sight, which may last a few days. An unusual risk of acupuncture includes spontaneous miscarriage, nerve damage and organ puncture. Infection is another possible risk, however since this office uses only sterilized, disposable needles while maintaining a clean and safe environment, this is unlikely. Burns and scarring are potential risks of using moxibustion. I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on the acupuncturist to exercise judgments during the course of treatment, and decide what she thinks is in my best interest, based upon the facts that are known at the time. I understand that the practitioner and administrative staff may review my medical records and reports, but all of my records will be kept confidential and will not be released without my written consent.

I will notify the acupuncturist, who is caring for me, if I become pregnant. By voluntarily signing below, I show that I have read or have had read to me, this consent to treatment. I intend this consent form to cover the entire course of treatment for both the present condition and for any future conditions for which I seek treatment(s).

Signature of patient or patient representative

Date