Heavenly Hollow

EAR SEEDS / AURICULOTHERAPY INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of ear seed services and other procedures within the practice of auriculotherapy on me (or on the patient/client named below, for whom I am legally responsible) by ***Julie Walsh @ Heavenly Hollow***. I understand that methods of treatment may include, but are not limited to ear seeds, auricular massage, laser, electric stimulation, palpating, and other forms of stimulation.

I understand that the ear seeds used may be in a variety of forms that include but are not limited to vaccaria seeds, gold and stainless steel. I will notify **Julie Walsh and or Cassie Walsh @ Heavenly Hollow** if I have a known allergy or sensitivity to gold, nickel, latex or any metals and adhesives. I will immediately notify a member of the staff of any unanticipated or unpleasant effects associated with adhesives or metals.

I have been informed that ear seeds and auriculotherapy is a generally safe method of treatment, but that it may have some side effects including dizziness, feeling faint, bruising, itchiness, burning, numbness, tingling or pain on the ear that may last a few days.
Unusual risks of ear seeds include: the ear seed dislodging or falling into the ear in which a saline wash performed by my doctor would be recommended to remove it. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I do not expect the **Heavenly Hollow/Julie Walsh or Cassie Walsh** or the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on **Julie Walsh / Heavenly Hollow** and the clinical staff to exercise judgment during treatment which they think at the time, based upon the facts then known is in my best interest. I will notify **Julie Walsh / Heavenly Hollow and or Staff** if I experience any side effects.

I will notify **Julie Walsh/ Heavenly Hollow and or Staff** if I am or become pregnant.

I understand that results are not guaranteed.

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

Medical Referral I understand that ear seeds and auriculotherapy is not meant to replace conventional biomedicine and that **Julie Walsh / Heavenly Hollow** recommends I see my physician for all health matters.

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 ear seeds and auriculotherapy procedures, and have had an opportunity to ask questions. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Printed Name of Participant:

_____

Signature of Participant: _____

Date:_____

MINOR INFORMATION: Name of Parent/Legal

Guardian:_____ Age (If A Minor)_____ Signature of Parent/Legal Guardian:_____ Date:_____