The Ivey Garden of Wellness
COMMUNITY ACUPUNCTURE CLINIC
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 acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below 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 the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, auricular acupuncture. I have been informed that acupuncture is a generally safe method of treatment, and 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. Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that acupuncture needles are very small; a different acupuncturist may remove the needles than the one who inserted them; and so I may need to help my acupuncturist locate all of the needles at the end of treatment and before I leave the clinic. I am willing to participate in my own treatment process.

I understand that The Ivey Garden of Wellness provides this treatment in a community setting. The purpose of this setting is to allow as many people as possible, while following current COVID safety guidelines, to access treatment and to decide for themselves how they wish to use acupuncture to manage their health. I understand that community acupuncture involves actual community with a wide variety of people, and may at times require some flexibility, patience, or understanding from me.

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

I understand the clinical and administrative staff may review my patient records; however, all my records will be kept confidential and will not be released without my written consent. I have been informed that I may stop treatment at any time. By signing this form, I am acknowledging that I have reviewed and accept the terms of HIPAA Privacy policies.

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.

Acupuncturist Name Jessica Ivey, LAc		**Acupuncture Clinic** The Ivey Garden of Wellness	
First Name	**Last Name**	**Preferred Name**	**DOB**
Email		**Phone**	
Signature (or Representative)		**Date**	
Name of Representative		**Relationship to Patient**	
Emergency Contact		**Phone**	
Do we have permission to contact you with clinic updates? Yes No		**Method? (circle one) Phone Text Email**	

Patient Information

Last Name	First Name (Legal):	Middle Initial:	Preferred Name:
Today's Date:	DOB:	Gender:	Pronouns:
Address:			
Phone Number:	Email:		
Preferred communication method:	Occupation:		
How did you hear about us?	Referred by?:		

Emergency Contact

Name and phone number of contact	Relationship to you

Consent to Communications

By signing below, you consent to receive clinic updates and notifications by email. Your email address is protected health information and will never be sold to a third party.

Patient Signature:	Date Signed:
Guardian Signature (if minor patient):	Date Signed:

Appointment Reminder Authorization

Please provide the way in which you prefer to be contacted regarding appointments:
(circle one)
Email Text Initial: Date Signed: