Leah M. Reeves Butler, Ph.D., M.Ac., M.O.M., MQP
NADA Certified AcuDetox Specialist
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Consent to Services

Services to be Provided

Treatments include but are not limited to: *acupuncture* (insertion of sterile, disposable needles), *acupressure*, *Tuina* (Chinese massage), *Qigong* (gentle breathing/movement exercises, *Gua Sha* (rubbing of the skin with a smooth object), *cupping* (suction via application of glass cups on the skin), *moxi-bustion* (burning of mugwort herb), *electrical stimulation*, *heat lamps,* and *Chinese herbal medicine and nutritional counseling*. I understand I may refuse any of these techniques at any time.

Effectiveness & Outcomes

Acupuncture serves individuals with a wide range of complaints including both acute and chronic healthcare issues. I understand results vary for each individual, and I acknowledge that I have not received any guarantees or promises as to the results from the services to be provided.

Risks/Possible Side Effects

Treatment may result in certain side effects and, though rare, can include: local bruising, slight bleeding, dizziness, fainting, temporary pain/discomfort, burning from moxa/lamps, digestive/intestinal upset or skin irritation from herbs, temporary aggravation of symptoms existing prior to treatment, and, in very rare occasions, pneumothorax. Any herbs or supplements recommended to me are from plant, animal & mineral sources and traditionally considered safe in Chinese Medicine practice.

Client Responsibilities

It is my responsibility as a client to inform my acupuncturist of: all aspects of my health; any concerns I may have before, during, or after treatments; and, as service progresses, to inform my acupuncturist of any changes that occur. I understand that some treatment methods may be inappropriate during pregnancy, so I will notify my practitioner if I am pregnant or aiming to become so or suspect pregnancy at any time.

An acupuncturist is not a substitute for a medical doctor and will not suggest the ceasing of medical treatment. It is my responsibility to consult with my doctor before altering any prescribed medications or treatments. I understand that if there is an emergency, or a worsening of my health condition, or if a new condition arises, that I should consult a licensed physician.

Payment & Cancellation Policy

I have been informed of and agree to the fees for service, and I understand that payment is due when the services are provided. If I do not cancel an appointment by phone or text message at least 24 hours in advance, then I am liable for the full amount of the missed appointment except in health & family emergencies. I understand that I will pay a $35 fee for any returned checks. I also understand that repeated fiscal or other offenses (e.g., abusive behavior) by me may result in refusal of services.

I have read (or have had read to me) and understand the information in this form, and I understand the possible risks involved. I am free to ask questions regarding this form and treatment methods at any time. I understand that I have the right to refuse or discontinue any treatment at any time. I understand such refusal may also affect expected results. I hereby voluntarily consent to be treated within the scope of practice of acupuncture & herbal medicine by Leah M. Reeves Butler.

_____
Patient Name (and Parent or Guardian Name if client is a minor)

_____ _____
Patient Signature (or Parent or Guardian if client is a minor) Date

Notice of Privacy Practices

Healthcare privacy acts require that healthcare professionals give their clients a Notice of Privacy Practices and that clients sign in acknowledgement that they received the notice.

During your course of treatment, I will use and disclose your Protected Health Information only for treatment, in consult with other healthcare practitioners upon your written approval, and when required by law. If at any time your case is discussed for educational purposes or in consult with other healthcare professionals not previously approved by you, any personally identifiable information will be completely omitted and protected to the fullest extent capable. Upon written request, you have the right to request additional restrictions on the use and disclosure of your Protected Health Information, as well as the right to review or obtain a copy of your health record from me. You will be contacted by me when necessary using the phone number, postal, and/or e-mail address you have provided unless you specifically request otherwise.

If you have any questions about your rights or believe your privacy has been violated in any way, please let me know so we may remedy the issue.

I acknowledge I have received and understand this Notice of Privacy Practices. _____
Patient Signature (or Parent or Guardian if client is a minor)