



Dr. Tiffani Alwazan, DC, ND, L.Ac.  
Healthy Sticks PLLC

## INFORMED CONSENT TO TREAT

I \_\_\_\_\_ understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care.

Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

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, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), 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 appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: 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 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.

I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician.

Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue. 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, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure. I understand that I **must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter).**

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.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with

prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm 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 agree with the current or future recommendations for care. 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.

**Notice to Pregnant Women:** All female patients must inform the supervising practitioner if they know or suspect they are pregnant as some procedures and therapies described herein may present a risk to the pregnancy.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
**Print patient name here**

*If the patient is a minor or unable to consent:*

\_\_\_\_\_  
Signature of person legally responsible for the patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name of person legally authorized here



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### **Authorization and Release Agreement Form**

I \_\_\_\_\_ hereby agree to pay my account as services are provided. If for any reason there is a balance owing on my account, I agree to pay promptly upon receipt of a monthly statement.

Our office does not accept any co-pays from any type of insurance.

### **Cancellation Policy**

Due to the nature of the services that we provide, we ask that if you will be late, 15 minutes or more for any appointment, please call our office before arrival to make sure the space will be available for you to receive treatment.

By signing below, you agree to give our practitioner 24-hour notice for cancellations. Any late cancellations or no show will result in a \$28 fee. By signing below, you hereby agree that you have read all the contents of this page thoroughly; you understand all the possible risk factors and authorize treatment by our facility. If you do not understand or have questions about the information above, please feel free to speak with one of our assistants.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
**Print name here**

**HEALTHY STICKS PLLC**

**Financial Policy**

Healthy Sticks PLLC maintains a financial policy that seeks to make services affordable and accessible to all.

**Appointment fee** – to make a reservation online or by phone the client will pay \$28. The *appointment fee* will be applied to the cost of the in-person or telehealth visit.

**Late cancellation fee** – to make sure clients may be seen promptly and as soon as possible, we respectfully request cancellations be made 24 hours in advance. Clients who fail to cancel in a timely manner will be charged \$28 *late cancellation fee*.

**Refunds** – when a payment is refunded to a client, no electronic processing fee can be refunded.

**Declined payments** – When an electronic payment is subsequently declined by a financial institution, the amount charged by the financial institution will become the responsibility of the client.

By signing below, you agree to give our practitioner 24-hour notice for cancellations. Any late cancellations or no show will result in a \$28 fee. By signing below, you hereby agree that you have read all the contents of this page thoroughly; you understand all the appointment fee, cancellation fee, refund, and declined payment policies. If you do not understand or have questions about the information above, please feel free to speak with one of our assistants.

I \_\_\_\_\_ agree to the above financial policy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name here



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### Confidential Patient Information

Date \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Number of Children: \_\_\_\_\_ Martial Status: S M Other

Sex: M F Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Office Phone: not required Office Address: not required

Name of emergency contact: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_

### HEALTH HISTORY

*Have you ever suffered from (please check yes or no):*

	Yes	No		Yes	No
Dizziness			Asthma		
Backaches			Neuritis		
Heart trouble			Digestive Disorders		
Diabetes			Nervousness		
Tuberculosis			Sinus trouble		
Arthritis			Anemia		
Headaches			Cancer		

Purpose of Appointment: \_\_\_\_\_

Other doctors seen for this condition: \_\_\_\_\_

Referred by: \_\_\_\_\_ Date of Last Physical Exam: \_\_\_\_\_

Have you been treated for any health condition by a physician in the past year? Yes / No

Describe: \_\_\_\_\_

Remarks and additional information: \_\_\_\_\_

Current Medications: \_\_\_\_\_

\_\_\_\_\_

Current Supplements: \_\_\_\_\_

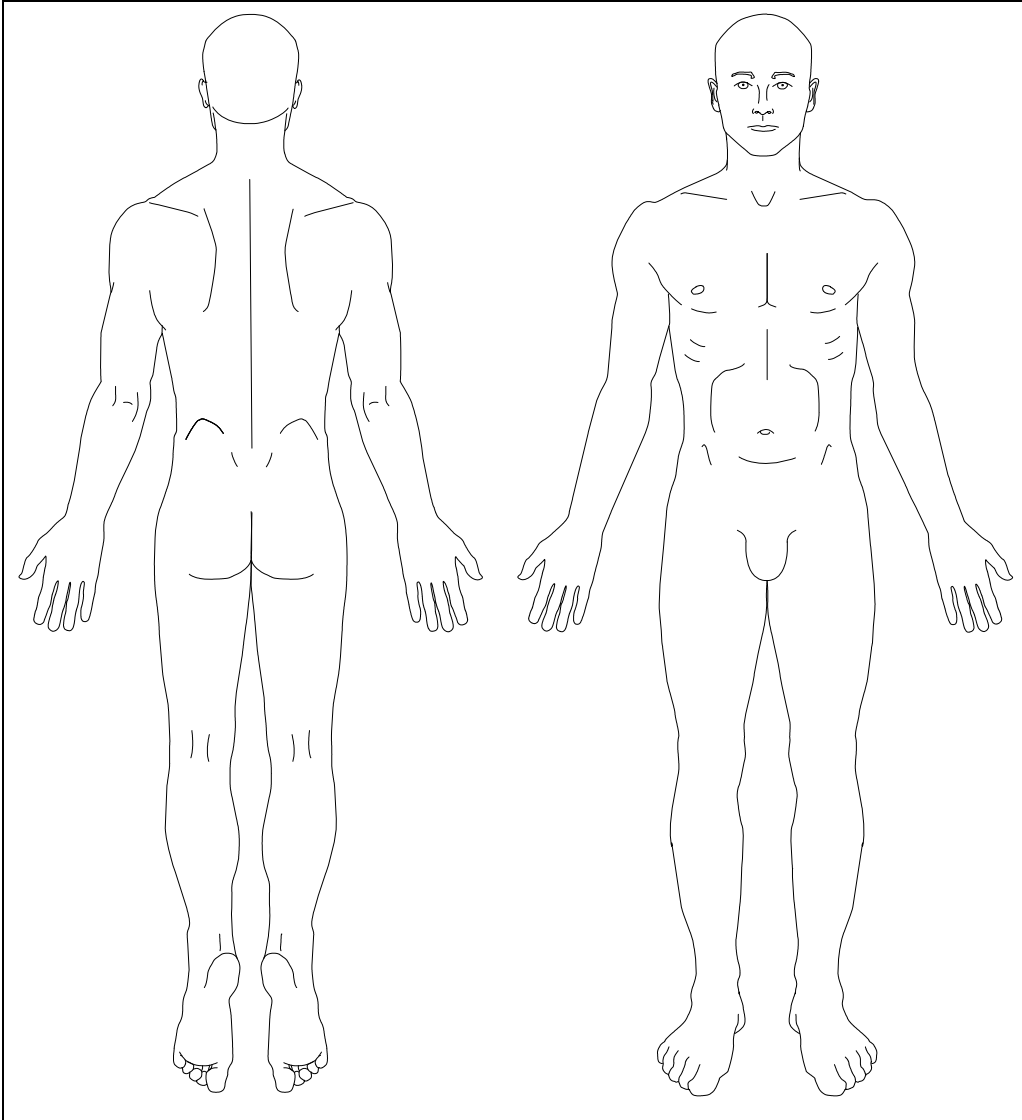
\_\_\_\_\_

Patient Initials: \_\_\_\_\_

Please shade in on the picture above your symptoms at the current time.

Circle any symptoms: Pain, numbness, tingling.

Please estimate the intensity at the time on a 0 (Min) - 10 (Max) scale: \_\_\_\_\_



HEALTH HISTORY: *check all that apply*

Patient Initials: \_\_\_\_\_

Conditions you have had

- AIDS / HIV
- Alcoholism
- Allergies
- ALS (Lou Gehrig's)
- Alzheimer's
- Anemia
- Arthritis
- Asthma
- Birth Defects
- Bleeding Disorder
- Breast Cancer
- Colitis / Crohn's / IBS
- Colon Cancer
- COPD
- Depression
- Diabetes
- Drug Abuse
- Epilepsy
- Glaucoma
- Gout
- Heart Disease
- Hepatitis
- Herpes / Shingles
- High Blood Pressure
- High Cholesterol
- Kidney Disease
- Liver Disease
- Mental Illness
- Multiple Sclerosis
- Osteoporosis
- Parkinson's
- Pneumonia
- Prostate Cancer
- Sickle Cell Anemia
- Stroke
- Suicide
- Thyroid / Goiter
- Tuberculosis
- Ulcers
- Other:

Devices Currently Used

- Pacemaker
- Implants of any kind
- Joint Replacement
- Braces (neck, back, knee)
- Orthotics

Current Past

- Pain not relieved by rest
- Fever

Current Past

- Chills
- Night Sweats
- Fatigue
- Weight Loss or Gain
- Headaches
- Tremors

- Dizziness
- Numbness / Tingling
- Loss of Sensation
- Change in Memory

Last Physical Exam:

- \_\_\_\_/\_\_\_\_
- Normal
  - Abnormal

Skin

- Dryness
- Itching
- Bruise Easily
- Change in Mole(s)
- Nail Changes
- Hair Changes
- Acne

Eye, Ear, Nose,

Throat

- Last Eye Exam: \_\_\_\_/\_\_\_\_
- Eye Pain
  - Glaucoma
  - Change in Vision
  - Ear Pain
  - Ear Ringing
  - Change in hearing
  - Change in smelling
  - Change in taste
  - Change in voice
  - Trouble Swallowing
  - Hoarseness

Gastrointestinal

- Bowel Incontinence
- Change in Bowel

Habits

- Abdominal Pain
- Nausea
- Bloating
- Belching / Gas
- Heartburn
- Indigestion
- Constipation
- Diarrhea
- Undigested Food
- Hemorrhoids
- Poor appetite
- Change in appetite

Current Past

- Bloody Stool
- Black / Tarry Stool
- Diverticulitis
- Vomiting
- Vomiting Blood
- Ulcers

Last Colonoscopy: \_\_\_\_/\_\_\_\_

- Normal
- Abnormal

Respiratory

- Difficult Breathing
- Chronic Cough
- Phlegm

- Cough up Blood
- Wheezing

Cardiovascular

- Pain over heart
- High blood pressure
- Low blood pressure
- Irregular Heartbeat
- Murmur
- Palpitations
- Previous Heart trouble
- Cold or blue hands / feet
- Swelling of ankles
- Varicose veins

Last Cholesterol Test:

- \_\_\_\_/\_\_\_\_
- Normal
  - Abnormal

Genitourinary

- Bladder incontinence
- Frequent Urination
- Overnight more than twice
- Painful urination
- Difficulty starting flow
- Blood in urine
- Urinary infection
- Kidney stones
- Discharge
- STD

Men Only

- Testicular swelling / pain
- Prostate problems

Last Prostate Exam:

\_\_\_\_/\_\_\_\_

Current Past Women Only

- Infertility
- Hot flashes
- Lumps in breast
- Vaginal discharge

Last PAP: \_\_\_\_/\_\_\_\_

- Normal
- Abnormal

Last Mammogram:

- \_\_\_\_/\_\_\_\_
- Normal
  - Abnormal

Menstrual Periods

- Age Onset: \_\_\_\_
- Avg. Days of flow: \_\_\_\_
- Avg. Cycle: \_\_\_\_ days

Menstrual Flow

- Reg.
- Irreg.
- Pain /cramps
- Menopause – age: \_\_\_\_

Are you pregnant?

- No
- Yes: \_\_\_\_

Months: \_\_\_\_\_

Birth control Method:

\_\_\_\_\_

Number of Children

- \_\_\_\_ Born alive
- \_\_\_\_ Cesarean
- \_\_\_\_ Premature
- \_\_\_\_ Stillborn
- \_\_\_\_ Miscarriages

Childhood Diseases

- Chicken Pox
- Measles / Mumps
- Polio
- Rheumatic Fever

Immunizations

(dates)

- Polio: \_\_\_\_/\_\_\_\_
- Tetanus: \_\_\_\_/\_\_\_\_
- Hepatitis: \_\_\_\_/\_\_\_\_
- Flu: \_\_\_\_/\_\_\_\_
- Pneumonia: \_\_\_\_/\_\_\_\_

Lifestyle

- Water: cups/day \_\_\_\_
- Exercise: x/week \_\_\_\_
- Sleep: hours/night \_\_\_\_
- Alcohol: drinks/day \_\_\_\_
- Smoke: packs/day \_\_\_\_
- Previous Smoker
- Start Date: \_\_\_\_/\_\_\_\_
- End Date: \_\_\_\_/\_\_\_\_

Patient Initials: \_\_\_\_\_

Please describe your average daily diet. *Be specific.*

Morning:

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Lunch:

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Dinner:

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Snacks: \_\_\_\_\_ How Often? \_\_\_\_\_