CONSENT FORM

Kate Pagliasotti, M.S., L.Ac
Inner Court Acupuncture

I consent to acupuncture treatments and related procedures, associated with Oriental Medicine, by Kate Pagliasotti, MS LAc. 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, gua sha, cupping, electrical stimulation and massage.

(Initial here) _____

I have been given a written sheet of information which outlines potential side effects from these modalities listed above. I understand that while this document describes the most common risks of treatment, other side effects and risks may occur. I do not expect Kate Pagliasotti, MS LAc to be able to anticipate all possible risks and complications of treatment, but believe that she will use her judgement to act in my best interest during the course of my treatment, based on the facts that are known at the time.

(Initial here) _____

I have been given a copy of this office's privacy policy, which details how Kate Pagliasotti, MS LAc and her billing or administrative staff may use and disclose my health and personal information in order to determine my eligibility for coverage and bill and receive payment for health benefit claims on my behalf. I also understand that if I am being treated by other practitioners in this office, information relative to my treatment may be shared between practitioners to guarantee my best continued care.

(Initial here) _____

I will notify Kate Pagliasotti, MS LAc if I am attempting to conceive or have become pregnant during the course of treatment, have a bleeding disorder, a pacemaker, or a contagious disease. I will also notify her if there are any substantial changes to my health status, including changes in medication or a recent hospitalization.

(Initial here) _____

While Oriental Medicine has a great deal to offer has a health care system, it is not intended to replace the resources available through Western Medicine. I understand that it is in my best interest to continue regular care from my medical provider for diagnosed medical conditions, monitoring of prescription drug intake, changes in physiological or psychological symptoms, or for emergency medical care.

(Initial here) _____

By voluntarily signing below, I show that I have read or have had read to me this consent to treatment. I have been told about the risks and benefits of acupuncture and related modalities and have had the opportunity to ask questions, if I have them. I intend this consent form to cover the entire course of treatment for present conditions and for any future conditions for which I seek treatment. I also understand that I may terminate treatment at any time.

_____ _____

Signature of patient or patient's representative **Date**