whole self

Acupuncture and Chinese Herbal Medicine

Informed Consent to Treat Form

I, _____, herby authorize Linda M. Lofaro of WholeSelf, LLC, to diagnose and treat according to the professional standards of Traditional Chinese Medicine and her trained professional judgement and to remedy any unforeseen reactions to treatment procedures. I understand that treatment may include but is not limited to the following. (Only check boxes you DO NOT GIVE consent for.)

- ☐ Insertion of various size acupuncture needles in various locations. Acupuncture is considered very safe. Rare but possible side effects include bruising, pneumothorax, infection, induced miscarriage.
- ☐ Heat using a conventional heat lamp may cause redness of the skin.
- ☐ A skin scraping massage may leave redness or bruising on the skin and soreness lasting up to 5 days.
- ☐ Cupping to promote circulation may leave redness or bruising on the skin and soreness lasting up to 5 days.
- ☐ Electroacupuncture involving a non-painful electrical stimulation between two needles to address pain, numbness or to enhance acupuncture treatment.
- ☐ Bloodletting to improve circulation and disperse heat, involves pricking the skin to allow 4-5 drops of blood to be expressed.
- ☐ Tuina (chinese acupressure massage) used to unblock the pathways, relieve tension and pain.
- ☐ Chinese herbal medicine (as pills, powdered extracts, or tinctures) to be administered orally or topically. I am aware that adverse effects from herbs are rare but possible however initial prescriptions are intentionally mild to monitor for possible reactions and modified as needed.

I have the right to refuse any form of treatment and that reasonable efforts will be made to give me information so that I may make an educated decision regarding the duration and appropriateness of treatment. I understand that no promises or guarantees can be made regarding the outcome of treatment.

I am aware that my practitioner is licensed by the state of Arizona in Acupuncture and Chinese Herbs, Board Certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) and holds a Master's degree in Acupuncture and Oriental Medicine.

I HAVE / HAVE NOT (circle one) been examined by a licensed physician or other licensed health care provider with regard to my current condition. If yes, I have informed the acupuncturist of the diagnosis.

I HAVE / HAVE NOT (circle one) informed the practitioner of allergies to any substances.

I DO / DO NOT (circle one) have a pace maker.

I DO / DO NOT (circle one) have a bleeding disorder.

I AM / AM NOT (circle one) pregnant or possibly pregnant.

All of my questions, prior to receiving treatment, have been answered to my satisfaction.

Patient signature: _____ Date: _____

HIPAA Protection and Release of Information

AUTHORIZATION FORM

Name: _____ Date of Birth: _____/____/_____

WholeSelf, PLLC does not share any personal or health information with any other parties unless given permission, *except in the event of a life emergency*. If you want information shared with anyone, please indicate by filling in the information below.

Release of Information

[ ] I authorize **WholeSelf, PLLC** to release certain information including the diagnosis and treatment records, as well as, necessary information to resolve claims and health benefit coverage, or for medical purposes when coordinating with another licensed healthcare professional when necessary for my health and safety. This information may be released to: (provide full name(s))

[ ] Spouse_____

[ ] Child(ren)_____

_____

[ ] Insurance Company_____

[ ] Legal Entity_____

[ ] Referring Physician _____

[ ] Physician I've Referred to _____

[ ] I do not authorize the release of any information to anyone for any reason.

This authorization will remain in effect until an amended authorization supersedes it.

Signature of Member: _____Date:_____

I understand that I have a right to change or revoke this authorization via written notice to **WholeSelf, PLLC,** which will apply to actions taken after change document is on file.

You may request to have and/or review a copy WholeSelf's Notice of Privacy Practices which are in compliance with federal and state law.

Legal Representatives Only:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Print Name of Legal Representative: _____

Signature of Legal Representative: _____ Date: _____