Fertile Ground: Informed Consent

I, _____, hereby voluntarily consent to be treated with acupuncture and other traditional Chinese medical methods administered by a Licensed Acupuncturist at Fertile Ground. This authorization includes treatments to remedy any unforeseen conditions or reactions to treatment procedures.

I understand that acupuncture is performed by inserting sterilized, single-use needles through the skin at certain body points in an attempt to stimulate and improve body function and/or relieve pain. I understand that Fertile Ground meets or exceeds all standards for ensuring sterility set by the Centers for Disease Control and Prevention (CDC) and conforms to guidelines for Clean Needle Technique (CNT) established for acupuncturists by the National Commission for the Certification of Acupuncturists and Oriental Medicine (NCCAOM).

I am aware that my practitioner may use other Chinese medical techniques including, but not limited to, heat therapies (moxa, heat lamps), bleeding, cupping, dermal friction (gua sha), massage (tui na), acupressure, electrical stimulation, food therapy and Chinese herbal therapy.

Although they are rare, I am aware that certain adverse side effects could possibly result from acupuncture. These include, but are not limited to, transient bruising, pain or discomfort, bleeding, weakness, fainting, nausea, the remote possibility of a broken needle, infection, or pneumothorax, and the possible temporary aggravation of symptoms existing prior to treatment. Herbal remedies have side effects including by not limited to gastrointestinal disturbance. Moxibustion can cause burns and cupping causes bruising.

I understand that the diagnosis and treatment plan I am given by Fertile Ground is based on traditional Chinese medical principles and that my diagnosis does not constitute a Western biomedical diagnosis. I understand that it is my responsibility to be evaluated by a physician for my condition if I have not already done so, and also if my circumstances change or warrant. If I am concurrently undergoing Western medical treatment, it is my responsibility to advise my physician of any herbal supplements I am taking, and also to inform my acupuncturist of any pharmaceuticals I am taking or of any changes in my current Western medical treatment.

I understand that I have a right to have all my questions satisfactorily answered and that I may stop treatment at any time. I understand that no promises or guarantees can be made regarding the outcome 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 continuing care with Fertile Ground. All of my current questions have been answered to my satisfaction.

_____ _____

Signature of Patient or Authorized Representative Date

_____ _____

Witness Signature Date

HIPAA Consent

Consent for Purposes of Treatment, Payment and Health Care Operation

I consent to the use or disclosure of my identifiable health information by Fertile Ground LLC for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me at Fertile Ground may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Fertile Ground is not required to agree to the restrictions that I may request. However, if Fertile Ground does agree to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time except to the extent that Fertile Ground has taken action in reliance on this consent.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Fertile Ground's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Fertile Ground and is available at the front desk. This Notice of Privacy Practices also describes my rights and the duties of my practitioners and Fertile Ground with respect to my identifiable health information.

Fertile Ground reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by requesting the most current notice during any office visit.

_____ _____

Signature of Patient or Authorized Representative Date

_____ _____

Witness Signature Date