Shaul Hendel, L.Ac.

PATIENT ADVISORY TO CONSULT A PHYSICIAN

We are committed to your health and well being. While acupuncture and Oriental medicine has a great deal to offer as a health care system, it cannot replace the resources available through biomedical physicians. Consequently, we recommend that you consult a physician regarding any condition or conditions for which you are seeking acupuncture and Oriental medicine treatment.

To comply with Article 160, Section 821 1.1 (b) of NYS Education law, we request that you read and sign the following statement:

WE, THE UNDERSIGNED, DO AFFIRM THAT_____ (patient) HAS BEEN ADVISED BY _____(licensed acupuncturist) TO CONSULT A PHYSICIAN REGARDING THE CONDITION(S) FOR WHICH SUCH PATIENT SEEKS ACUPUNCTURE TREATMENT.

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_____ _____

Patient Signature Date

_____ _____

Licensed Acupuncturist Signature Date

Shaul Hendel, L.Ac.

INFORMED CONSENT TO TREATMENT

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 the patient named below for whom I am legally responsible) by the acupuncturist named 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, cold laser therapy, magnetic resonance stimulation, dietary counseling and manual therapies such as acupressure.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, 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. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. No significant side effects have been identified with cold laser therapy and minor effects may include fatigue.

I understand that any herb recommendations made by the clinicians are done so in an unregulated environment in New York State and the practice of herbs is not specifically identified within scope of practice for a licensed acupuncturist in New York State. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that are recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, diarrhea, rashes, hives and tingling of the tongue. I will notify the clinical staff member who is caring for me if I am, or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and 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 results are not guaranteed.

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 portions of my records may be used for research purposes; however, my name and identifying information will not be disclosed.

By voluntarily signing below I show 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 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.

Print Patient Name	Signature of Patient (or Patient Representative)	Date

Print Name of Clinic Staff	Signature of Clinic Staff	Date