Patient Informed Consent to Treatment for Asher Acupuncture

R.A.c. License # 00368 & # 04770

This is a mandatory form from the College of Traditional Chinese Medicine Practitioners Association (CTCMA) governed by the BC Ministry of Health

(Sorry ☹ We dislike paperwork too! Thank you kindly)

I, or the person listed below, have discussed with my traditional Chinese medicine practitioner or acupuncturist the specifics of my assessment or treatment and understand the nature, risks and reasons for this procedure. I voluntarily consent to Traditional Chinese Medicine/Acupuncture and understand that I may withdraw my consent and halt my participation at any time.

1. I understand that some of the techniques used under the scope of Traditional Chinese Medicine include the use of sterile, single-use needles to penetrate the skin. Additional treatment methods can include, but are not limited to: acupuncture, acupressure, the electrical stimulation of needles, cupping or moxibustion, and Tuina (Chinese massage). Before any of these procedures are performed, my practitioner will discuss my treatment options and only proceed if my consent is given.
2. The risks and symptoms of treatments, which can include, but are not limited to: slight pain, light-headedness or nausea, soreness, bruising, bleeding or discolouration of the skin, and the possibility of other unforeseen risks. I freely accept the risks involved with my procedure
3. I will inform my practitioner if I currently have or develop any major health issues, if I suffer from any type of major bleeding disorder, or if I use a pacemaker.
4. I understand that I must let my practitioner know if I am carrying, or believe to have any infectious agents, including but at not limited to HIV, TB and Hepatitis.
5. I understand that there are no guarantees for the results of treatments. Traditional Chinese Medicine does not often provide an instant cure. The length of my treatment depends on the severity of my condition. In some cases, my symptoms may temporarily worsen before they begin to improve (Healing Crisis).
6. Cancellation policy requires 24 hour notice otherwise half the cost of the treatment will be charged. Please discuss on individual basis with practitioner. I am responsible for the full payment after services have been rendered. We only accept Cash or Cheque for our small family practice. Sorry if this is inconvenience
7. I have discussed the content of this form with my practitioner. I acknowledge that I have asked any questions I may have and received answers I understand. By signing this form, I give my informed consent for Traditional Chinese Medicine treatments.

____
Patient Signature

____
Date

____

Practitioner Signature

____
Date

Consent to Collect and Release Information (Sample Form D)
Clinic Name/Practitioner Name/Registration # Clinic Address
Clinic Phone Number

I ____, or my appointed representative____
(Print) (Print)

❑ Consent ❑ Do not consent

for Clinic __________________________________ to collect and release my general patient or medical information to other medical practitioners or health care providers/support workers, emergency personnel and/or any other relevant organizations.

In terms of information, the Clinic may collect any of the following:
- Contact information
- Personal or family medical history
- Medical insurance or billing/account information

In cases of emergencies or life threatening situations, medical or support staff workers may have to collect this information from family members or other listed contacts without your prior written consent.

How Your Information Will Be Used
Your personal information can be used or disclosed for the following reasons:
- For billing or account purposes
- To assist third-party insurance companies with insurance claims
- Referring your medical history to another health practitioner or health care provider
- To seek advice for potential treatment options
- To prevent or assist patients in cases of emergencies or threat to their health and safety
- To fulfill any obligations as mandated by law

Patient Access to information
I understand that my personal and medical history is available to me for my review under most circumstances. Cases where access to records be limited are:
- cases where access to information causes a threat to your life or personal health
- Where the law disallows access to information
- In the event where disclosure of information relates to any anticipated or actual legal proceedings or professional conduct proceedings.

[If applicable] I understand that a reproduction or translation fee may be incurred in accordance with the clinic's fee schedule.

Acknowledgment
I allow for medical personnel to use and disclose my information as outlined above.
I understand that I can access my personal health information except as outlined above.
I understand that I can withdraw my consent at any time, but it may directly affect the services I can receive. My personal information can still be used/disclosed if mandated by law.

Additional Comments or Restrictions: ____
____
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______________________________ ______________________________
Patient Signature Witnessed

______________________________ ______________________________
Date Date