THE OPENING POINT INFORMED CONSENT TO TREAT

Jennifer Gnisci, M.S., L.Ac.

I _____ hereby request and consent to the performance of Acupuncture and other related Chinese medicine procedures by Jennifer Gnisci, M.S., L.Ac. I understand that my signature on this form indicates that I have read the following, and understand that if I have any questions about this information, I should ask the practitioner.

1. **Nature of Treatment**: The treatment modalities may include acupuncture, acupressure, cupping, gua-sha, electrical stimulation acupuncture, AMMA & Zheng Gu Tui Na massage therapy, moxibustion, nutritional counseling, essential oils and Chinese herbs. I understand that the treatments will be explained to me prior to treatment for my condition.

2**. Purpose of Treatment**: I understand that the purpose of the treatment is to resolve my condition, the reason that I am requesting treatment. The procedures used will attempt to remedy bodily dysfunction or diseases, to modify or prevent the perception of pain, and to make normal the body's physiological functions.

3. **Risks of Treatment**: I understand that Chinese medicine procedures have been shown to be safe and effective. However, I understand that there are some uncommon risks. These may include:

- ❑ Mild discomfort during or after the insertion of a needle, dizziness, fainting, localized bruising or swelling, gastro-intestinal upset with the use of Chinese herbs, temporary aggravation of symptoms that existed prior to treatment; Some herbs and acupuncture points are contra-indicated during pregnancy. Please notify your practitioner if you **are or might** be pregnant.

4**. Use of Disposable Needles**: I understand that to prevent any possibility of infection from acupuncture, all needles used are pre-sterilized, one time use, surgical stainless steel needles that are disposed of after usage as medical waste. Needles are never reused.

5. **Unforeseen risks**: I understand that the practitioner can not anticipate or explain all risks and complications which may occur during or after treatment. I understand that they will exercise judgment based upon their determination of my best interests. I understand that I may stop treatment at any time.

Patient advisory to consult a physician: To comply with Article 160, section 8211.1 (b) of NYS Education law, we must advise that you consult a physician regarding your condition.

PAYMENT & APPOINTMENT POLICIES

PAYMENT POLICIES:

If my insurance does not pay for the treatment services, I agree to pay for them myself. Also, I agree to pay co-payments, deductibles, and/or coinsurances for treatment services as required by my policy.

ASSIGNMENT OF BENEFITS

I authorize the insurance company to make payment to the practitioner for my treatments and services.
I authorize release of information concerning my (or my child's) health care, advice and treatment provided only for the purpose of evaluating and administering claims for insurance benefits.

APPOINTMENT POLICIES:

Please be on time for appointments. Failure to cancel an appointment with less than 24 hours notice will result in a $50.00 charge. Please note that your insurance carrier is not responsible for this fee, you are. Your consideration is well appreciated.

HIPAA PRIVACY ACT ensures that all of your personal and health information remains confidential at all times between this office, your insurance company and you only. Should you have any questions about the privacy of your information at this office, you may ask the practitioner at any time.

Your signature indicates that you have read, understand and agree with the above information.

Signature of patient (or parent if minor) _____ Date _____