

**Jennifer Buys, Lac., LMT**  
License # AC00482; 6025  
927 NW Grant Avenue  
Corvallis, OR 97330  
541-231-5282

### **INTRODUCTION & INFORMED CONSENT**

Welcome! I thank you for entrusting me with your health care needs, and I am excited to partner with you to reach your goals. Please keep a copy of this letter for reference.

Your first visit will include a verbal review of important parts of your health history, as well as discussion of the primary reason for treatment. This information, together with a review of systems, will be used in conjunction with the hands-on portion of your evaluation to arrive at a treatment plan. My objective is to use the tools of acupuncture, hands on bodywork, Chinese herbal therapy, and dietary and lifestyle counseling in order to help you reach your goals. Treatment techniques are based on: my knowledge of best practices, my experience, and your needs and specific preferences. Approaches will vary and some may temporarily cause increased symptoms. Treatment length varies depending on the complexity of what we are treating, and whether it is an acute or chronic condition. Some patients come in for regular wellness tune-ups; others only come when they have a specific issue, be it musculoskeletal, internal medicine related, or for overall optimized health. If you are looking to improve your overall health and have a sincere interest in making the necessary lifestyle changes, then you've come to the right place.

If your insurance plan covers acupuncture, I can take your insurance information and do a detailed check to see exactly what coverage you have if you see me as a provider. If your visits with me are covered, I can bill insurance directly. You are responsible for payment in full of any deductibles, co-pays, or unpaid balances that are denied by the insurance provider. If there is no insurance coverage, full payment is due at the time of service.

#### **24 HOUR CANCELLATION POLICY:**

Because I am a solo practitioner, and your appointment time is reserved exclusively for you, appointments canceled with less than 24 hours notice may be charged the full amount of the session. Missed appointments will be charged the full amount of the session.

If you agree with these terms, please sign below:

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature (if necessary): \_\_\_\_\_

## **ACUPUNCTURE INFORMED CONSENT TO TREAT**

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 on the patient named below, for whom I am legally responsible) by **Jennifer Buys, Lac., LMT.**

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs need to be consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. 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.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese 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, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

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

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.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_