

Marie Yuann, LAc
Yuann Acupuncture
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(310) 968-8198

**PATIENT'S CONSENT FOR THE PURPOSES OF
TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

With my consent, Yuann Acupuncture may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Yuann Acupuncture's Notice of Privacy Practices for a more complete description of such uses.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Yuann Acupuncture reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Yuann Acupuncture's Privacy Officer.

With my consent, Yuann Acupuncture may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders and return calls requesting a call back.

By signing this form, I am consenting to Yuann Acupuncture's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, Marie Yuann, LAc may decline to provide treatment to me.

Patient's Signature

Date

Patient's Name (Print)

ADVISEMENT AS TO THE IMPORTANCE OF CONSULTING WITH A LICENSED PHYSICIAN

We, the undersigned, do affirm that _____ has been advised by Marie Yuann, LAc to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

Patient's Signature

Date

Marie Yuann, LAc

Date

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CONSENT TO TREATMENT FORM

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by Marie Yuann, LAc., a California State licensed acupuncturist.

Acupuncture/Moxibustion

I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Chinese Herbs

I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and call the Chinese Medical Clinic as soon as possible.

Acupressure/Tui-Na Massage

I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture

I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Patient's Signature

Date

Patient's Name (Print)

Date of Birth

The above patient is a minor and as his/her guardian or parent, I consent that _____ may receive acupuncture treatment from Marie Yuann, LAc, and have been advised as to all the modalities that may be used and have been informed of any associated risks.

Patient/Guardian Signature

Date