Informed Consent for Treatment

I, _____ *(Patient or legal guardian)*, do voluntarily, knowingly and willingly give my consent to treatment by holistic primary care, for myself or for the patient named below, for whom I am legally responsible. A number of different approaches are used. Dietary therapy, nutritional supplements, botanical medicine, homeopathy, acupuncture, physical medicine and lifestyle counseling are important tenets of holistic and alternative medicine. Individual diets and nutritional supplements are recommended to address deficiencies, treat disease processes and promote health. The benefits include increased energy, improved gastrointestinal function, improved immunity and general well-being.

We will take a thorough case history, perform pertinent physical examinations and, when necessary, take blood, urine or saliva samples. If your case requires, the physical may include more specific examinations. The doctor takes great care to treat each patient as an individual. Consideration is given when there are complicating factors such as pregnancy, advanced disease processes, autoimmune disease, multiple medications, or chronic illness. Treatment plans are tailored to the unique needs of the individual, and are created within the framework of the individual's current health status. As with any method of care, holistic medicine can involve some risk, such as allergic reactions to prescribed herbs and supplements, inconvenience of lifestyle changes, or adverse interactions between herbal and synthetic medicines. I understand it is my responsibility to provide information regarding any prescription or over the counter medications I am currently taking.

Acupuncture is the insertion of thin, sterile needles at specific acupuncture points located throughout the body. Acupuncture is used to balance the energy of the meridians and restore harmony to organ systems. Besides Acupuncture, other treatment modalities may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation and Tui-Na (Chinese massage).

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.

Chiropractic is a manual therapy that utilizes high-velocity, low-force manipulations on the joints of the spine and extremities, with the desired outcome of increased joint mobility and pain reduction. I understand and I am informed that, as is with all healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains.

I understand that the doctor will answer any questions that I have to the best of her ability. I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. I will rely on the doctor to exercise judgment during the course of the procedure which they feel at the time is in my best interests, based on the facts then known. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above.

I intend this consent form to cover the entire course of treatment. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

By voluntarily signing below I, _____ *(Patient or legal guardian)*, hereby certify that I have read this entire form, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions and that I consent to treatment with the modalities described above.

_____	_____
Patient Name (print)	**Staff/Admin Signature**
_____	_____
Signature (Patient/Guardian)	**Date**

Katie Gregory, DC, LAc
Phone: (630) 474-2720
Email: drkatiegregory@gmail.com