core healing llc
ryan marshall
M.A.T.C.M., Dipl.A.c, L.A.c

Informed Consent
Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I hereby request and consent to the performance of acupuncture treatments and other procedures on me (or on the patient named below), for who I am legally responsible, within the scope of the practice of the provider(s) of Core Healing LLC and/or licensed providers who now or in the future treat me while employed by, or working at this office or any other office or clinic, whether signatories to this form or not.

I understand the methods of treatment may include, but are not limited to: acupuncture. accupressure, cupping, moxibustion, electrical stimulation, manual therapies such as myofascial release and cranial sacral therapy, Chinese or western herbal medicine and supplements, infrared devices, gua sha, therapeutic exercise, medical qigong and nutritional counselling.

I have been informed that acupuncture is a safe method of treatment, but it may have side effects, including: bruising, numbness, or tingling near the needling sites that may last a few days; and dizziness or fainting. I understand that I should not move while the needles are being inserted, retained, or removed.
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 Core Healing LLC exclusively uses sterile, disposable needles, and maintains a clean and safe environment.
Burns and scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps.

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.

I understand that as part of my healthcare, or my legals dependent's healthcare, Core Healing, LLC creates and maintains health records describing health history, symptoms, examination and testresults, diagnoses, treatment, and any plans for future care or treatment.

I understand that this information serves as:
A basis for planning care and treatment. A basis for communicating among the many health care professionals who contribute to care. A source of information for applying diagnostic and medical information to a bill. A means for a third-party payer to verify that services billed were actually provided. A tool for routine healthcare operations such as assesing care quality and reviewing the competence of helthcare professionals.

I understand I have the following rights:
To object to the use of health information for directory purposes. To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon. To request restrictions as to how this health information may be used or disclosed to carry out treatment, payment or healthcare operations - and that the organization is to not required toagree to the restrictions requested.

I request the following restrictions to the use or disclosure of my health information: _____

X

PATIENT SIGNATURE (Date:)

(Or Patient Representative, and relationship to patient) Patient's Social Security Number

PLEASE REMEMBER TO ALSO SIGN THE ACCOMPANYING **ARBITRATION AGREEMENT**

X

Core Healing Provider, Ryan Marshall, MATCM,L.A.c., Dipl.Ac.