Root Alchemy Acupuncture
Blair Sylvan Grey, Doctor of Oriental Medicine
(505) 699-4188
www.elementalintegration.co
rootalchemy@cybermesa.com

Informed Consent for Acupuncture Treatment

I hereby request and consent to the performance of Oriental Medicine treatments, including acupuncture and other procedures on me by Blair Sylvan Grey, DOM. I understand that such treatments may include, but are not limited to acupuncture, electrical stimulation, TDP lamp, moxibustion, cupping/Gua Sha, sound therapy, essential oils, Chinese herbs, supplements, and lifestyle/dietary counseling.

I understand that acupuncture is generally a safe method of treatment, with few, but some possible side effects. These side effects include bruising or numbness at the needle site, dizziness, or fainting. There have been extremely rare instances of spontaneous miscarriage or pneumothorax. There may be bruising after cupping or Gua Sha. Moxibustion and the use of heat therapies may in rare instances cause burns or scarring.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that may be recommended are traditionally considered safe in the practice of Oriental Medicine. I understand that some herbs maybe inappropriate during pregnancy. If I experience any gastro-intestinal upset or allergic reactions to the herbs I will inform Blair Grey, DOM.

I will inform Blair Grey, DOM if I suspect or become pregnant. I will also notify her to any medications and supplements I take, and any change in them.

I do not expect Blair Grey, DOM to be able to anticipate and explain all possible risks and complications of treatment, and I understand the results cannot be guaranteed, and that I wish to rely on Blair Grey, DOM to exercise proper judgment during the course of the procedure which Blair Grey, DOM feels at the time, based on the facts known, is in my best interest.

All my records will be kept confidential and will not be released without my written consent. I have the opportunity to discuss with Blair Grey, DOM the nature and purpose of acupuncture treatments and other procedures.

I, (Print Patient Name)_____ have read, or have read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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:_____/_____/_____
Relationship to patient (if signed by their personal representative):_____

CANCELLATION POLICY

Because my practice is by appointment only, your appointment is time reserved exclusively for you. If you need to reschedule or cancel an appointment, I require a minimum of 24 hours notice. **Please call (505) 699-4188 to inform me.**

More than 24 hours notice: Consultation will be cancelled at no charge. We can reschedule.

Less than 24 hours notice: 50% of consultation will be charged. (For consultations a refund for the other 50% can be arranged or applied to the rescheduled time.)

Failure to notify me: 100% of session price will be charged and no refund.