Kauai North Shore Acupuncture Project Release and Waiver of Liability

Informed Consent

I hereby voluntarily request and consent to be treated, or give permission for my child to be treated, with acupuncture and other techniques based on Traditional Asian Medicine. I understand I may be given diet/lifestyle recommendations. The procedures involved in this treatment have been explained to me. I have not been guaranteed any success concerning the uses and effects of these treatments. I understand that I am free to discontinue treatment at any time.

Possible Side Effects/Healing Reactions

I understand that these treatments may result in certain side effects, including local bruising, numbness, slight bleeding, fainting, temporary pain or discomfort, and temporary aggravation or symptoms existing prior to treatment. Bruising and/or blistering are common side effects of cupping. Unusual and rare risks of acupuncture include nerve damage, organ puncture, and infection. I have read the information on this page and understand the possible risk involved.

Medical Referral

I understand that I should consult a licensed physician for appropriate medical evaluation and treatment of the conditions for which I am seeking acupuncture treatment. Treatment from this practitioner is not a substitute for appropriate medical treatment by a licensed physician. I have been advised that if there is a worsening of my ailment or condition, or if it does not improved within the time estimated by the acupuncturist at the beginning of the treatment, or if a new ailment or condition arises, I should again consult a licensed physician. If I am presently under the medical care of a physician, I have been advised to continue all medications and treatments as prescribed until such time as my physical deems it appropriate to reduce or discontinue the medication or treatments. I certify that I have informed Kauai North Shore Acupuncture Project/Linda Ming Lee Acupuncture and Integrative Health of all known physical, mental, and medical conditions and medications, including possible pregnancy, and that I will notify KNSAP/LMLAIH of any changes.

Infectious Disease/Clean Needle Procedures

I understand that there is infectious disease carried through the air, through physical contact, and through body fluids. I understand that universally prescribed precautions will be utilized during treatments to guard against the spread of infection, including the use of sterile, prepackaged disposable needles. Needles that are used for my treatment are used only on me, and are inserted according to clean procedures based on nationally prescribed standards. Needles are disposed of as medical waste immediately after use. I understand that my questions about the safety of any procedure or treatment or the precautions taken by the practitioner are most welcome and will be answered as fully as possible. I understand I have a right to refuse any treatment or procedure. I have read this form carefully, and have felt free to ask any questions.

Privacy

Since several people are being treated in the same room at once it is important that we work together to respect your privacy and the privacy of others. Let us know if there are certain topics that need extra discretions or if you would prefer to do your intake in a more private setting. If you happen to overhear someone's private information, please keep it to yourself, as you would want others to do the same for you.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complication of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff things at the time, based on the facts then known is in my best interest. I understand that results are not guaranteed.

By voluntarily signing below, I confirm that I have read the above consent to treatment, have been informed about the risks and benefits or acupuncture and other procedures, and have had the opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions (s) for which I seek treatment at the Princeville Yoga Studio. As a participant, I, my heirs, and legal representatives unconditionally agree to release any claim that I might have against KNSAP, its practitioners and staff, or Princeville Yoga LLC for any injury or damage which I might sustain, in whole or in part.

I have read the above Release and Waiver of Liability and fully understand and accept its contents. I voluntarily agree to all the terms and conditions.

Print Name (s) of Patient / Guardian

Signature (s)

Date