Willow Health & Wellness Center
3090 Belgium Road
Baldwinsville, NY 13027

Gail Mead, MS, LAc
(315) 398-4708
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Mead Acupuncture

I. PATIENT ADVISORY TO CONSULT A PHYSICIAN

We are committed to your health and well being. We believe that while Oriental Medicine has a great deal to offer as a health care system, it cannot totally replace the resources available through biomedical physicians. Consequently, we recommend that you consult a physician regarding any condition or conditions for which you are seeking acupuncture treatment.

To comply with Article 160, Section 821 1.1 (b) of NYS Education law, we request that you read and sign the following statement:

WE, THE UNDERSIGNED, DO AFFIRM THAT_____(patient)

HAS BEEN ADVISED BY Gail Mead, M.S., L.Ac. (licensed acupuncturist) TO CONSULT A PHYSICIAN REGARDING THE

CONDITION(S) FOR WHICH SUCH PATIENT SEEKS ACUPUNTURE TREATMENT.

_____ _____
Patient or Representative Signature Date

_____ _____
Gail Mead, M.S., L.Ac. Date

II. INFORMED CONSENT TO ACUPUNCTURE TREATMENT

- I consent to acupuncture treatments and other procedures associated with the practice of Traditional Chinese Medicine provided by Gail Mead, M.S., L.Ac.. I have discussed the nature and purpose of my treatment with the member of the clinical staff named below.
- I understand that methods of treatment may include but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, and bodywork therapies such as Medical Massage, and Tui Na (Chinese Massage).
- I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping.
- Rare and unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax).
- Infection is another possible risk, although this site uses sterile, disposable needles and maintains a clean and safe environment.
- Burns and/or scarring are a potential risk of moxibustion.
- I understand that while this document describes the major risks of treatment, other side effects and risks may occur.
- I will notify the clinical staff member who is caring for me if I am, or become pregnant.
- I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment.
- I understand the clinical and administrative staff may review my medical records and lab reports and that portions of my records may be used for teaching or research purposes, however my name and identifying information will not be disclosed. Otherwise all of my records will be kept confidential and will not be released to any party without my written consent.

By voluntarily signing below I show that I have read, or have had read to me, this 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.

To be completed by patient (or patient's representative if the **patient is a minor or is physically or legally incapacitated**

_____ _____
Signature of Patient or Representative Date Consent Completed

_____ _____
Gail Mead, M.S., L.Ac. – Clinical Staff Date Consent Completed

A copy of this form will be provided to patient upon request