INFORMED CONSENT FOR TREATMENT

I, _____ (Date of Birth: ___/___/_____)
(Name of Patient – Please print)
agree to abide by the guidelines of the Inova TCM Clinic (ITC). I do voluntarily consent to be treated with Acupuncture & Oriental Medicine and Naturopathic Medicine by Dr. Teerawong Kasiolarn and Licensed Acupuncturist Sabrina Frazier, LAc. The procedures involved in this treatment have been explained to me. I understand that I may be treated with the insertion of needles/and or application of heat to the skin, the use of cups, moxibustion, herbal preparation, nutritional supplementation, or e-stim. I have been advised that acupuncture may result in certain side effects, including local bruising, slight bleeding and fainting, temporary pain or discomfort, and temporary aggravations of symptoms existing prior to treatments. Conventional medical treatment may be used in an emergency. I have been advised that there is infectious disease carried through the air, through physical contact, and through body fluids. I understand that Dr. Teerawong Kasiolarn and Sabrina Frazier follow universally prescribed precautions to guard against the spread of infection and that only sterile, prepackaged, disposable needles are used. Needles that are used for my treatment are used only by me, and are inserted according to clean needle procedures based on nationally prescribed standards. I understand that in case of pregnancy or delayed menstrual flow, I must warn Dr. Teerawong Kasiolarn and Sabrina Frazier prior to treatment. I understand that in case of pregnancy, acupuncture treatments may be reevaluated. If I have a heart pacemaker or any medical implants, Dr. Teerawong Kasiolarn and Sabrina Frazier must be informed of this. I have not been guaranteed any success concerning the uses and effects of Acupuncture & Oriental Medicine and Naturopathic Medicine. I understand that I am free to discontinue treatment at any time.

I understand that the Commonwealth of Virginia does not license or otherwise recognize Naturopathic doctors. Therefore, Dr. Teerawong Kasiolarn is not permitted to diagnose or treat a given diagnosis of a disease/illness. The role of my Naturopathic doctor is supportive, adjunctive and consultative in nature to assist in my health and well-being. I further understand that my Naturopathic doctor may work with other physicians or health care providers. I further understand, if I need additional assistance or medical care, I will be referred to others within the community. I further understand my Naturopathic care may be performed by Dr. Teerawong Kasiolarn. I have had an opportunity to discuss with Dr. Teerawong Kasiolarn the nature and purpose of Naturopathic care and related procedures.

In agreement with federal and state law, I agree to allow ITC to deliver the necessary care to me in order to provide continuity of care and treatment. ITC, licensed acupuncturists, and/or my Naturopathic doctor may obtain from any source and examine and use, or discuss and disclose, my medical records and information to ITC personnel and agents, other healthcare providers, medical records auditors, professional committees, care evaluators and governmental agencies. This information can include, but is not limited to: medical history, examinations, diagnoses, treatments any psychiatric, drug and alcohol abuse or genetic testing information, or HIV/AIDS information. This consent to release and obtain information is valid until revoked. I may revoke this consent in writing at any time, except with regard to disclosures that have already been made in reliance on such consent. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my Naturopathic doctor/licensed acupuncturist. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at ITC. I understand ITC's fee, appointment, and cancellation policies as well.

I hereby acknowledge having read and understood the above points concerning my treatment. I have asked any questions I may have regarding this process and this form, and I have had my questions answered to my satisfaction.

Patient Signature/Legal Guardian: _____ Date: _____

Naturopathic Doctor/Licensed Acupuncturist Signature: _____ Date: _____

Recommendation for Examination by a Physician

I, Teerawong Kasiolarn, ND, LAc, MSAc, Sabrina Frazier, LAc, MAc, recommend to you _____
(Licensed Acupuncturist) (Name of Patient – Please print)

that you be examined by a Physician regarding the condition for which you are seeking acupuncture treatment.

I understand this recommendation.

Patient Signature/Legal Guardian: _____ Date: _____

Virginia law requires that I give this form to you if I do not have written evidence that you have received a diagnostic exam in the last six months from a licensed practitioner of medicine, osteopathy, chiropractic or podiatry regarding the condition for which you are seeking treatment. (Code of Virginia §54.1-2956.9, 18 VAC 85-110-10).

Acupuncturist Signature: _____ Date: _____