Peter Wu, LAc
930 Broadway Suite 100
Massapequa, NY 11758
Appointments (516)778-7228 Email: peterwu.lac@gmail.com

Patient Name					
Address					
City		State		Zip Code	
Cell number		home number			
Date of Birth		Soc. Sec.			
Emergency Contact		Telephone			
Relationship		Email			

Insurance Carrier					
Address					
City		State		Zip Code	
Telephone					
Policy #		Group #			
Policy Holder		Date of Brith			

Sec. Insurance					
Address					
City		State		Zip Code	
Telephone					
Policy #		Group #			
Policy Holder		Date of Brith			

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Consent to Treatment Form: Acupuncture & Oriental Medicine

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me(or on the patient named below, for whom I am legally responsible) by any licensed acupuncturist who now or in the future treatment while employed by, working or associated with or serving as backup for the acupuncturist named below, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, TuiNa (oriental massage), Oriental herbal medicine and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. Herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last for a few days and dizziness or fainting. 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 the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. 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 Oriental 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, 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.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment and I wish to reply on the clinical staff to exercise judgement fur ing th course of treatment which hte clinical staff thinks at the time based upon the facts known is in my best interest, I understand that results are not guaranteed.

I understand that the clinical and administrative staff may review my patient records and lab reports but all of records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that Ihave read, or have had read to me, the above treatments have been told about the risks and benefits of acupuncture and other procedures and have had an opportunity to asks questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which i seek treatment,

Signature: _____ Date:_____

Printed Name: _____

Office Signature: _____ Date: _____

Peter Wu, LAc
Intrinsic Wellness
930 N. Broadway, Suite 100
Massapequa NY 11758
Telephone: (516)778-7228

Medical Massage Consent Form

I, _____ understand that the massage treatment given to me at Intrinsic Wellness is performed by a Licensed Massage Therapist (LMT) for the purpose of health and wellness, improved circulation, pain management and other effects determined by experience and research.

I understand that massage therapist do not diagnose medical conditions, nor do they perform spinal manipulations or chiropractic adjustments.

I understand that massage therapy can be a valuable complement to health care provided by medical doctors, chiropractic physicians, practitioners of Traditional Chinese Medicine (Acupuncture), naturopathic physicians and psychiatrists; however it is not a substitute for seeking medical help from a physician. In addition, I understand that sometimes massage therapy may not alleviate the area of discomfort and do not hold Intrinsic Wellness or the massage therapist responsible for my physical well-being.

I have stated all my known medical conditions, treatments and medications and agree to inform the massage therapist of any changes. I understand that any changes may impact the massage therapy I receive.

My signature below confirms my agreement to the general policies, privacy policies and consent statements above.

NAME: _____

DATE: _____