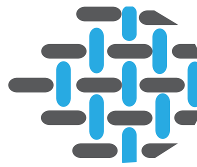
JOVA
ACUPUNCTURE



# INFORMED CONSENT AND PRIVACY POLICY

I hereby request and consent to Traditional Chinese Medicine treatments including and not limited to acupuncture by James Mezzapelli, L.Ac., MSTOM.

I understand that Traditional Chinese Medicine treatments may include, but are not limited to acupuncture, herbal medicine, cupping, moxibustion, Tui Na massage, Gua Sha, Qigong, and lifestyle counseling. I understand that herbs may need to be prepared and the teas consumed according to instructions provided to me either orally or in written form. The herbs may have 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 understand that while acupuncture is generally a very safe method of treatment with few, but some possible side effects including bruising, numbness at the needle site, dizziness or fainting. Bruising is a common side effect of cupping and Gua Sha. Moxibustion and the use of heat therapies may in very rare instances cause burning or scarring. Chinese Herbs (which are mostly from plant, animal and mineral sources), that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy and along with other herbs or prescription medication. I will notify a staff member if I become or suspect that I am pregnant. I will notify a staff member what drugs (medicinal or recreational) and supplements I take and if there is any change to them. I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications and I understand that results cannot be guaranteed.

I understand that clinical and administrative staff may review my patient records, but all records will be kept confidential and will not be released without my written consent. I also understand that Jova Acupuncture Center will periodically send me receipts, newsletters and office announcements, but that my name and contact information will never be released to any other business or organization. I have be notified that the full Privacy Policy is available only and I understand that I may receive a print copy if I request.

By voluntarily signing below, I show that I have read, or have read to me, the above consent to treatment, have been notified about the benefits and risks of the above 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 conditions(s) for which I seek treatment.

______________________________________________________________

Patient Signature **X** Date (relation to patient)
(or patient representative)

______________________________________________________________

Office Signature Date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