Christopher Dye, MS, L.Ac.

41 Union Sq. suite 511 / 911 Park Ave. 917-214-1272

Confidential Patient Contact Information

Name _____ Age _____ Date of Birth _____

Address_____City _____

State _____ Zip _____ E-mail _____

Tel: Home _____ Cell_____ Work _____

How did you find out about Christopher? _____

Name & Tel # of Physician _____

Emergency Contact Name & Tel# _____

Relationship _____

All patients are advised under New York State Law to consult a physician regarding the condition or conditions for which they are seeking acupuncture treatment. In addition, patients are responsible for seeking the advice and treatment of a physician should their symptoms change for the worse, or should a new condition arise. In the case of a patient becoming pregnant, she agrees to notify Christopher. Patients understand that while acupuncture and Chinese medicine is generally very safe, all medical procedures entail some risk.

All patients may ask to see HIPAA privacy practices in regards to medical records at any time.

Christopher may occasionally send information via mail or email regarding his practice. Patients may opt out of receiving this information at any time.

If sessions are covered by insurance and the insurance company sends payment to the patient, then the patient agrees to give Christopher a check for the full amount of payment and all accompanying paperwork.

Cancellation Policy

I understand that there is a 24-hour cancellation policy. I agree to pay the full price of a session if I cancel less than 24 hours within the scheduled appointment time or fail to show up within 20minutes of the scheduled treatment time.

Signature of Patient or Patient Representative **Date**

ACUPUNCTURE INFORMED CONSENT TO TREAT

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 the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below 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, Tui-Na (Chinese massage), Chinese herbal medicine, essential oils and nutritional counseling. I understand that the herbs or essential oils may need to be prepared and the teas or blends consumed or applied according to the instructions provided orally and in writing. The herbs or essential oils 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 or essential oils.

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 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 effect and risks may occur. The herbs, essential oils and nutritional supplements (which are 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. Some possible side effects of using herbs or essential oils are nausea, gas, stomachache, vomiting, headache, 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 rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

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

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

PATIENT SIGNATURE **X** (Date)

(Or
(Indicate relationship if signing for patient)