healthflow
integrative health centre

Suite 117, 1330 15th Avenue SW
Calgary, Alberta
403.313.4354 ♦ info@healthflow.ca

Informed Consent for Care

I hereby request and consent to the performance of acupuncture and other procedures within the scope of Chinese medicine, as necessary, on me or on the patient named below (for whom I am legally responsible) by a licensed acupuncturist and/or traditional Chinese medicine doctor (TCMD) in the clinic.

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, nutritional and lifestyle counseling. I understand the herbal medicines may need to be prepared as teas and are taken according to the doctor's instructions. Some herbs, though considered safe, can be toxic in large doses or if taken inappropriately. Some side effects include, and are not limited to; upset stomach, gas, nausea, vomiting, headache, diarrhea, hives, rashes and tingling of the tongue. 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 generally a safe and natural method of treatment that may have side effects. This includes, but is not limited to; localized bruising or minor bleeding, minor pain or soreness, nausea, dizziness, fainting, infection, shock, stuck or bent needles, and although rare, spontaneous miscarriage and possibly perforated internal organs.

I recognise that it is my responsibility to notify the doctor if I become pregnant, or of any allergies, medications, pacemakers or artificial implants.

I have been advised that the doctor is fully trained in clean needle technique and only pre-sterilized, single use needles are used and properly disposed of after every treatment.

I do not expect the doctor and administrative staff to anticipate and explain all possible risks and complications of treatment, and wish to rely on the doctor to exercise judgment during the course of treatment which he/she thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I authorize the collection and use of personal information as is required for therapeutic treatment and related administrative purpose. I understand that all of my personal information is confidential and will not be released without my signed consent.

Name:_____Date:_____

Signature or Parent/Guardian signature:_____

Informed Consent to Services and Fees

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I understand the fees are:

Initial examination and treatment - 75 minutes	$110.00
Subsequent treatments - 60 minutes	$75
Initial examination only - 30 minutes	$50
Cupping session - 30 minutes	$50
Follow up examination - 15 to 30 minutes	$25
5 Treatment package	$350
10 Treatment package	$675

I am informed that all fees are collected at the time of service and a $50 fee will be charged for failure to provide 24 hours notice of cancellation.

I acknowledge that I will be charged the full fee of an appointment if I am late and the appointment will end at the scheduled time.

Signature:_____Date:_____