Katrina Haskell, Licensed Acupuncturist

I. PATIENT ADVISORY TO CONSULT A PHYSICIAN

I am committed to your health and well being, and while acupuncture and Oriental Medicine have a great deal to offer as a health care system, it cannot totally replace the resources available through biomedical physicians. Consequently, I must recommend that you consult a physician regarding any condition or conditions for which you are seeking acupuncture treatment.

To comply with Article 160, Section 821.1 (b) of NYS Education law, I request that you read and sign the following statement:

> WE THE UNDERSIGNED, DO AFFIRM THAT_____(patient) HAS BEEN ADVISED BY KATRINA HASKELL, M.S., L.Ac. TO CONSULT A PHYSICIAN REGARDING THE CONDITION OR CONDITIONS FOR WHICH SUCH PATIENT SEEKS ACUPUNCTURE TREATMENT.

_____	_____	_____	_____
(Patient Signature)	(date)	(Practitioner's Signature)	(date)

II. INFORMED CONSENT TO ACUPUNCTURE TREATMENT

I consent to acupuncture treatments and other procedures associated with Traditional Oriental Medicine by Katrina Haskell, L.Ac. or one of her associates.

I understand that the methods of treatment may include, but are not limited to, Acupuncture, Moxibustion, Cupping, Gua Sha, Electric Stimulation, and Tui Na (Chinese Medical Massage).

I have been informed that acupuncture is a safe method of treatment, but that it may have 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 miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although Katrina Haskell, L.Ac. and her Associates use sterile, disposable needles and maintain a clean, safe environment. Burns and/or scarring are a potential risk of moxibustion. 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) which may be recommended are traditionally considered safe, 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, vomiting, diarrhea, rashes, hives and tingling of the tongue.

I understand that the herbs need to be prepared and the tea consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify Katrina Haskell, L.Ac. or one of her Associates of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I will notify Katrina Haskell, L.Ac., or her Associate who is caring for me if I am or become pregnant.

I do not expect Katrina Haskell, L.Ac., or her Associates to be able to anticipate or explain all possible risks and complications of treatment, and I wish to rely on Katrina Haskell, L.Ac., and her Associates to exercise judgment during the course of treatment which she or her Associates thinks at the time, based upon the facts known to them, is in my best interests.

I understand that Katrina Haskell, L.Ac., her Associates, Colleagues, and their administrative staffs may review my medical records and that portions of my records may be used for teaching, research or consultation purposes, however, my name and identifying information will not be disclosed to non-Acupuncturists. Otherwise, all of my records will be kept confidential and will not be released to any party without my consent.

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

To be completed by patient (or patient's representative if patient is a minor or is physically or legally incapacitated.)	To be completed by Katrina Haskell, L.Ac.
_____	_____
PRINT name of patient	PRINT name of Licensed Acupuncturist
_____	_____
SIGNATURE of patient or representative	SIGNATURE of Licensed Acupuncturist
_____	_____
PRINT name of patient representative	DATE consent completed