

MIDDLE WAY ACUPUNCTURE INSTITUTE PLLC

NATURE-BASED INTEGRATED STUDIES IN ACUPUNCTURE

STUDENT CLINIC TREATMENT CONSENT FORM

I, _____, voluntarily consent to the treatment of Acupuncture. I understand this is a student clinic and that I will be treated by a student who is being supervised by a licensed Acupuncturist.

I understand that the Acupuncture treatment will be performed by the insertion of sterile, disposable needles through the skin, or by the application of heat, or by some combination of both at certain points on my body; and that such treatment is intended to improve body function and relieve pain.

I have been informed that although rare, some side effects may result from my Acupuncture treatment. These could include some minor pain or discomfort, localized bruising, fainting, nausea and the temporary aggravation of pre-existing conditions.

I have been informed that I may stop treatment at any time. All questions I have asked have been fully answered to my satisfaction.

Signature _____ Date _____

GROUP EXPOSURE WAIVER FORM

Privacy is something almost everyone is concerned about when receiving any form of healthcare. All information revealed during an individual acupuncture appointment is protected by the healthcare provider-patient privilege. However, in this particular group setting, confidentiality is partially lost due to:

- (1) The group appointment schedule,
- (2) Visibility of patients participating in the student clinic, and
- (3) Health care information shared and disclosed by other participants.

By signing below, you agree that Middle Way Acupuncture Institute will not be considered liable for financial or other damages resulting from any breach of confidentiality committed by other persons in this location. Along with the students, faculty and Middle Way Acupuncture Institute's commitment to maintain your privacy, you will also have a responsibility to protect each other's privacy. Nothing in this waiver shall affect the privacy or confidentiality of individual medical records maintained by Middle Way Acupuncture Institute.

Name _____ Date _____

Signature _____

* WE RECOMMEND SIGNING BOTH SO YOUR PAPER WORK IS READY FOR EITHER OCCASION