**Consent for Purposes of Treatment and Health Care Operation**

I, ...................................................... hereby agree and consent to the performance of acupuncture and related Traditional Chinese Medicine (TCM) procedures. I understand that such procedures may include, but are not limited to, acupuncture, moxibustion, cupping, massage therapy, infrared heat lamp, and nutritional therapy advice based on Traditional Chinese Medical theory.

I have been informed that in all acupuncture treatments that only sterile, disposable needles are used according to the British Acupuncture Council (BAcC) standards of safe practice. I have been informed that acupuncture is a safe method of treatment, but may have some side effects including bruising, numbness or tingling, dizziness or fainting, minor swelling, minor bleeding or that a hematoma may occur at the site of insertion and may last a few days. A sensation of light-headedness may occur after acupuncture treatment. I will immediately notify the acupuncturist if I experience any symptoms or problems. I understand that I should not make significant movements while the needles are being inserted, manipulated, retained or removed.

I am relying on the TCM practitioner to exercise judgment during the course of my treatment, trusting that, based upon facts the known, this treatment plan is appropriate and is in my best interest. I understand that acupuncture and other methods used during treatment are not a substitute for treatment by a medical doctor. Also, at any given time throughout the treatment, I may request the practitioner to stop, modify or change the treatment plan. I also understand that results are not guaranteed.

I state that I do not have the following conditions: pregnancy, bleeding disorders, pacemaker, local infections; or am currently taking anti-coagulants. If I have any of the above conditions, I have listed them here:

By voluntarily signing below I hereby certify that I have (i) read this entire form (li) have been told about the risks and benefits of acupuncture and other procedures (ili) have had the opportunity to ask questions (iv) consented to treatment with the modalities described above. I intend this consent form to cover the entire course of treatment to be performed for my present condition and for any future conditions for which I seek treatment.

I have been advised that all medical records and discussions during treatment are strictly confidential however, I offer my consent for this acupuncturist to contact my GP and/or health professionals if necessary and with my permission.

**Data Protection Policy**

Under the Data Protection (1998) Act, we are required to advise our patients on our Data Protection Policy.

As part of the Patient Record, Paula Macklin Creasy Acupuncture is required to retain information for the purpose of consultation for treatment, recording subsequent treatments, and for the use of third party medical practitioners only, at the written request of the patient.

Upon completion of the Patient Details Form, Data Protection and Consent Form, all paper files and information therein may be stored for a period of 8 years.

All information provided will be treated as confidential and will not be given to any other person or organization without the written consent of the patient concerned.

I the undersigned (or authorized guardian) acknowledge that I have read the Data Protection Policy (above) and do hereby give consent to the practitioner to maintain records for the purpose outlined within the policy

Printed name of patient Signature of patient

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date