



AGAPE HEALING ARTS

Health & Wellness Center

Teacher Name: _____

Date of class: _____ Time of Class: _____

By signing below I agree that I am participating in a workshop which includes acupuncture with Dr Bella Lauren from Agape Healing Arts. I have read the waiver on the back of this form and I fully accept responsibility for my decision to participate in this workshop. By signing below, I further agree, along with my successors and assigns, to hold Agape Healing Arts and its teachers, directors, practitioners & officers harmless in any way should any problem arise from my participation including, but not limited to, personal injury. As with any physical activity, I have been encouraged to seek the approval of my physician or medical advisor prior to participating.

Thank you for signing in:

Print Name:	Sign Name:	Email

"LOVE WINS"



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HIPPA CLIENT CONFIDENTIALITY AND RELEASE FORM. I understand this modality is not a replacement for medical care. The practitioner does not diagnose medical illness, disease or other physical or mental conditions unless specified under his/her professional scope of practice. As such, the practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform spinal manipulations (unless specified under his/her professional scope of practice). The practitioner may recommend referral to a qualified health care professional for any physical or emotional conditions I may have. I have stated all my known conditions and take it upon myself to keep the therapist/practitioner updated on my health. Confidentiality of medical and personal information obtained during the course of the practitioner's work is of the utmost importance. HIPAA regulations require all practitioners obtain a signed release form from their client before taking any information about them. The best way to be fully compliant is to obtain this release signature at the initial consultation. Clients should receive a copy of the form they signed (upon request), and the practitioner maintains a copy for their records (Please sign and date below to confirm you have read the above HIPPA CLIENT CONFIDENTIALITY AND RELEASE).

INFORMED CONSENT & PROCEDURE. I hereby give my full consent for treatment with Dr. Bella Lauren DOM, AP, from Agape Healing Arts. I hereby request and consent to the performance of Oriental medicine, acupuncture treatments and other procedures within the scope of the practice of / Oriental Medicine Acupuncture / Massage on me (or on the patient named below, for whom I am legally responsible) by the Therapist named above and/or other therapist / 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 & Therapist named above, including those working at the clinic or office listed above 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 (Oriental massage), Oriental herbal medicine, therapeutic body work and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs 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. 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 and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine, 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, 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.

"LOVE WINS"