

INTERN CLINIC PATIENT FORM

PAGE 01

First Name _____ **Last Name** _____

Phone _____ **Email** _____

I understand that the treatment modalities performed at the ESATM Student Clinic may include but are not limited to: Acupuncture [meaning the practice of acupuncture and/or herbal medicine based on traditional medical theories including but not limited to stimulation of a certain point or points near the surface of the body by the insertion of needles to prevent or to normalize the physiological functions, including pain control, for the treatment of diseases or dysfunctions of the body and includes the techniques of electro-acupuncture, mechanical stimulation, adjunctive therapies and moxibustion]; tui na and other forms of East Asian massage, cupping, gua sha, eastern nutrition therapy, lifestyle and behavioral education; laser stimulation, thermal methods, magnets, breathing techniques and exercise; and Herbal medicine.

INITIAL HERE

I understand that acupuncture is a generally safe method of treatment with few but some possible side effects. The potential risks of acupuncture are: slight pain or discomfort at the site of needle insertion, infection, bruises, numbness at the site of needle insertion, weakness, dizziness, fainting, nausea and the possible exacerbation of problematic systems existing prior to acupuncture treatment. Unusual and infrequent but possible risks of acupuncture include miscarriage; nerve damage and organ puncture including pneumothorax (puncture of the lung). Burns and/or scarring are a potential risk of moxibustion or other heat therapies. I understand that while the major risks are described in this document that other possible side effects or risks may occur.

INITIAL HERE

I understand the importance of providing a current and/or updated health history that includes notifying interns of any changes in the following: prescribed medications, over-the-counter medications, herbs, nutritional supplements, etc. that I might be taking or that have been prescribed to me external to the ESATM Student Clinic.

INITIAL HERE

I understand that herbs need to be prepared, consumed and/or topically applied according to instructions. I understand that some herbs may have an unpleasant aroma or taste. I understand that if my condition were to change [that I suddenly caught a cold or had a fever] to something that was different from the issue for which I was prescribed the formulation that I should stop taking the preparation and contact the clinic to schedule another appointment for reassessment of my current condition. I will immediately notify a member of the clinic staff of any unanticipated or unpleasant effects associated with the consumption of herbs.

INITIAL HERE

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PAGE 02

First Name _____

Last Name _____

In support of the educational and didactic function of the ESATM Student Clinic I understand that details of my case may be used for teaching or for research purposes. Publication of any articles or research papers will not include any identifying information.

INITIAL HERE

PREGNANCY: I understand that the herbs and nutritional supplements [primarily derived from plant, animal and mineral sources] that may be recommended and are traditionally considered safe though some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy or that herbs and/or acupuncture treatment may be limited or denied during pregnancy. Therefore I will notify the ESATM Student Clinic, clinical supervisor and interns if there is any possibility that I am or become pregnant. I understand that possible side effects while taking herbs may include but are not limited to: gas and bloating, epigastric or abdominal discomfort, stomach ache, nausea, vomiting, diarrhea, constipation, skin rashes and/or itchiness, headache, tingling of the tongue.

INITIAL HERE

PLEASE NOTE: The treatment that you will receive at the Intern Clinic of the Eastern School of Acupuncture and Traditional Medicine will be administered by students who are in their last year of training. This means that the intern/s treating you is/are NOT a Licensed Acupuncturist/s and is/are not yet qualified to perform acupuncture treatments external to the Intern Clinic. However, the intern is closely supervised by an acupuncturist who is licensed to practice acupuncture within the State of New Jersey. Herbal interns may or may not be licensed practitioners but maintain 'Intern' status within the ESATM Student Clinic and the patient needs to be aware that the treatment that they will receive from the Herbal Intern is being administered by an intern under Clinical Supervision as well as is in the process of completing a course of study in Herbology for which their internship is part.

INITIAL HERE

I am aware that the ESATM student clinic accepts credit and debit cards, checks and cash as payment for treatment rendered. I am aware and understand that the Intern Clinic of the Eastern School of Acupuncture and Traditional Medicine does not accept Insurance reimbursement as a form of payment and will NOT provide Diagnostic Codes (ICD-10 codes), Procedural Codes (CPT codes), or Practitioner EIN, Tax ID, NPI or License numbers for insurance claims.

Any patient is entitled to receive a receipt upon payment.

INITIAL HERE

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PAGE 03

First Name _____ **Last Name** _____

It is confirmed that I have had an opportunity to ask questions. It is my intention that this consent form functions to cover the entire course of treatment for any present and future condition/s for which I may seek treatment from the Intern Clinic of the Eastern School of Acupuncture and Traditional Medicine. "I therefore render my consent to the above practices and acknowledge that I understand the aforementioned policies and procedures."

Patient or Representative

Sign here

Relationship to the Patient

Date

Clinic Supervisor, L.Ac

Sign here

Print Name

ESATM Intern

Sign here

Print Name