

## Consent Form

Name \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

Preferred Phone \_\_\_\_\_ Email \_\_\_\_\_

Occupation: \_\_\_\_\_ Blood Type: A/B/AB/O

GP: \_\_\_\_\_/Ph. \_\_\_\_\_ Last visit: \_\_\_\_/\_\_\_\_/\_\_\_\_

Referred by \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_ Phone \_\_\_\_\_

I hereby request and consent to the performance of acupuncture treatments and other complementary medicine procedures on me (or on the patient named above, for whom I am legally responsible) by Helena Fitzgerald. I understand that methods or treatment may include, but are not limited to: acupuncture, Shonishin, Moxibustion, cupping, moving cupping, electrical stimulation, supplement recommendations, and nutritional counseling.

Acupuncture attempts to normalise physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infection and scarring. There may be some bruising after cupping.

I do not expect Helena to be able to anticipate and explain all risks and complications. I wish to rely on Helena to exercise judgment during the course of the procedure, which she feels at the time, based upon the facts then known, is in my best interests.

I understand that Helena would expect me as the patient to bring to her attention any issues which might prejudice treatment, such as the presence of pacemakers, infectious disease, any serious illness, or any impending operations.

By signing below, I agree to the above-named procedures. I intend 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.

By signing below, I give consent to Helena Fitzgerald to correspond directly with my GP and/or medical team regarding my case.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
Patient's/Patient Representative's