MANDATORY DISCLOSURE & INFORMED CONSENT

Acupuncture Wellness & Fertility Clinic • 415 E Golf Rd. Suite 119 • Arlington Heights IL 60005 • (847)957.7877

Education and Experience

Ginette Slaiher earned her Master of Science Degree in Traditional Chinese Medicine from the Colorado School of Traditional Chinese Medicine. This program consists of 2,850 hours of education, including 795 hours of clinical practice. She is certified as a Diplomat of Oriental Medicine by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM). This includes certification in Clean Needle Technique and board certification in Chinese Herbal Medicine. She is also board certified in Oriental reproductive medicine by the American Board of Oriental Reproductive Medicine (ABORM).

Ginette's training includes adjunctive Chinese medicine therapies such as, gua sha, cupping, electro-acupuncture, moxabustion auriculotherapy (ear acupuncture), tui na, dietary, and lifestyle recommendations.

Ginette's licenses or certifications have never been suspended or revoked.

The practice complies with the rules and regulations stated by the Illinois Department of Health, including proper sanitation of the acupuncture clinic, and the practice of Clean Needle Technique. Only single-use, disposable factory sterilized needles are utilized.

Fee Schedule

Initial Consultation and Treatment (60-90 minutes): $75 or $110 (60 minute initial or 90 minute initial)
Follow-up Treatment (45-60 minutes): $65
*Herbs are not included in the above pricing and are additional

***Please note that we have a 24 hour cancellation policy. For late cancellations there is a $30 cancellation fee**

Patients Rights

- The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.
- The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.
- In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.
- The practice of acupuncture is regulated by the Illinois Department of Financial and Professional Regulation (IDFPR). Please feel free to contact them if you have comments, questions, or complaints at the following address and phone number : 100 W. Randolph, 9th Floor, Chicago, Illinois 60601 Telephone (888) 473-4858

I have read and understand the above consent. By signing below I agree to all terms and conditions stipulated by this document. I intend this form to cover the entire course of treatment for my condition and for any future condition(s) for which I seek treatment.

Print Name _____

Signature of Patient/Person Authorized to Consent_____

Date_____

Informed Consent

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of Traditional Chinese Medicine on me (or on the patient named below, for whom I am legally responsible) by Ginette Slaiher.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: nerve damage, pneumothorax, local bruising, infection, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

_____ Patients Initials

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I should stop taking them and inform my practitioner as soon as possible.

_____ Patients Initials

Tui Na & Cupping: I understand that I may also be given Tui na & cupping as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles, or aches, and the possible aggravation of symptoms existing prior to treatment. Cupping may leave temporary discolorations, lasting from hours to days, which is a normal and healthy response that may result from this modality. I understand that I may stop the treatment if it is too uncomfortable.

_____ Patients Initials

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: all adverse effects of Acupuncture listed above and possibly electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

_____ Patients Initials

I have discussed the nature and purpose of my treatment with the acupuncturist named above. I understand that there are no guarantees regarding cure or improvement of my condition. I understand that there may be limitations to the care provided and that in my best interest I may be referred to another healthcare provider who may be more qualified to treat my condition. I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications. I permit the acupuncturist to determine and/or alter the course of treatment which the acupuncturist judges to be in my best interest based upon the facts known. I understand that I have the choice to accept or reject treatment at any time.

I have read and understand the above consent. By signing below I agree to all terms and conditions stipulated by this document. I intend this form to cover the entire course of treatment for my condition and for any future condition(s) for which I seek treatment.

Print Name _____

Signature of Patient/Person Authorized to Consent_____

Date_____