#### BLUE LOTUS HEALTH AND WELLNESS

Dr. Lowell M. Chodosh ND, LAc

For Returning Veterans Project Patients Using

MASSAGE, ACUPUNCTURE, NATUROPATHY AND TELEMEDICINE

CONSENT AND REGISTRATION FORM

Name:

Address:

City: Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_

Phone (Home): (Work): (Cell):

E-mail:

Male ❒ Female ❒ Date of Birth:

Occupation: Employed By:

Marital Status: Number of children:

What contact number do you prefer I use? \_\_\_\_\_\_\_ May I leave a message? \_\_\_\_\_\_

Best time to reach you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: Phone: Relation:

Name of Medical Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:

Are you a Veteran or Active Duty? Please circle. Military branch?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This is a confidential record of your medical history. Information contained in it will not be released to any person unless authorized by you.

#### Health Concerns

Any health concerns, pain or problems I should be aware of before giving a massage?

\_\_\_\_\_\_

\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_ **Current Medical Conditions**

Are there medical conditions I should be aware of ?

|  |  |  |
| --- | --- | --- |
| Medical Condition | For how long? | When did it begin Are you being treated |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

#### Medications

Please list all prescription and non-prescription medications you are currently taking including Marijuana. PLEASE NOTE: **I request that you not use Marijuana before the massage as it will affect the application and benefit of the therapies used.**

|  |  |  |
| --- | --- | --- |
| Medication | Dosage | When did you begin this medication? |
|  |  |  |
|  |  |  |

INFORMED CONSENT AND AGREEMENT

# Oriental Medicine (OM)

# Acupuncture can be used as a full body treatment or as an optional treatment in the ears and/or scalp during the massage. It refers to the insertion of small disposable, sterilized needles through the skin into underlying tissues at specific points on the surface of the body. Other optional OM therapies include: Moxa, Guasha and/or Electrical stimulation–as electroacupuncture or microcurrent therapy.

**Naturopathic Medicine**

Naturopathic medicine is the treatment and prevention of diseases and disorders by natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual using a variety of treatment modalities that stimulate the body’s inherent healing capacity. Various natural therapies can be used including homeopathy, energy medicine, herbal medicine, manipulation, injection therapies, vitamin and nutritional supplementation, counseling, and diet.

**Massage**

Massage is any bodywork massage technique or combination of techniques including shiatsu, cranial sacral therapy, and polarity therapy.

**Telemedicine**

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

* Patient medical records
* Medical images
* Live two-way audio and video
* Output data from medical devices and sound and video files
* Audio and/or video recording of our interactions

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

**Expected Benefits:**

* Improved access to medical care by enabling a patient to remain in his/her provider’s office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
* More efficient medical evaluation and management.
* Obtaining expertise of a distant specialist.

**Possible Risks:**

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

* In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
* Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
* In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
* In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;

**By signing this form, I understand the following:**

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My provider has explained the alternatives to my satisfaction.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform my provider of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

**Declaration, Consent and Agreement to Treatment**

* Even the gentlest therapies have their complications. Certain conditions such as pregnancy, lactation, those on multiple medications or who have certain diseases such as diabetes, heart, liver or kidney disease, or are very young need to proceed with caution in treatment. It is very important that you inform your acupuncturist/naturopath immediately of:
* any disease process that you are suffering from
* if you are on any medication or over the counter drugs
* If you are pregnant, suspect you are pregnant, actively attempting to become pregnant or if you are breast-feeding

There are some potential health risks to treatment using acupuncture, TCM and massage.

These include but are not limited to:

* Aggravation of pre-existing symptoms
* Allergic reactions to anything topically used
* Pain, bruising, redness or injury from Acupuncture, Cupping , Guasha or Massage
* Fainting or puncturing of an organ with Acupuncture needles, accidental burning of the skin from the use of Moxa

**Use of Disposable Needles:** To reduce the possibility of infection from acupuncture, all

needles are pre-sterilized, one-time-use needles made of surgical stainless steel needles.

After each treatment they are disposed of as medical waste, needles are never reused.

**Consent**

I request and consent to the performance of acupuncture, massage, naturopathic therapies and the use of telemedicine. I also consent to housecalls, when necessary, through prior arrangement. I understand that I am free to withdraw my consent and that I may stop treatment or any procedure at any time. I understand that my signature in this form indicates that I have read and understood the preceding information regarding my treatment. I therefore acknowledge that I have received a full and complete explanation and understand the nature of the treatment or services that I have agreed to receive by Lowell M. Chodosh ND, LAc. and hereby authorize and consent to treatment. Futhermore, I agree that if I miss an appointment without informing Dr. Chodosh beforehand, I will no longer be a patient.

Patient’s name (please print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_