ABSOLUTE BALANCE ACUPUNCTURE CLINIC
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INFORMED CONSENT AND PRIVACY POLICY

I hereby request and consent to the performance of Oriental Medicine treatments including acupuncture and other procedures on me by Taya Volin, L.Ac, MD (Russia), Dipl.Ac. and/or other licensed acupuncturists/practitioners of Oriental Medicine who now or in the future treat me while employed by, working or associated with Taya Volin, L.Ac.

I understand that Oriental Medicine treatments may include, but are not limited to, acupuncture, micropuncture, moxabustion, cupping, Tuina and other East Asian forms of massage, Gua Sha, traditional Chinese herbal medicine, Qigong, and lifestyle/dietary counseling. I understand that herbs may need to be prepared and the teas consumed according to instructions provided to me either orally or in written form. The herbal teas may have an unpleasant smell and taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of herbs.

I understand that acupuncture is generally a very safe method of treatment with few, but some possible side effects, including bruising, numbness at the needle site, dizziness or fainting. Bruising is a common side effect of cupping and Gua Sha. Moxabustion and the use of heat therapies may in rare instances cause burning or scarring. Chinese herbs (which are from plant, animal and mineral sources) that are recommended are traditionally considered safe when practiced by professional practitioners of Oriental Medicine, although some may be toxic in large doses. I understand that some herbs are inappropriate during pregnancy and along with other herbs or prescription medication. I will notify a staff member if I become or suspect that I am pregnant. I will also notify a staff member what drugs (medicinal or recreational) and supplements I take and if there is any change in them. I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications and I understand results cannot be guaranteed.

I understand that clinical and administrative staff may review my patient records, but all records will be kept confidential and will not be released without my written consent. I also understand that office of Taya Volin will from time to time send me information via mail or e-mail including but not limited to receipts, newsletters and office announcements, but that my name and contact information will *never* be released to any other business or organization. I have been notified that the full Taya Volin's practice Privacy Policy is available online and I understand that I may receive a print copy if I request.

By voluntarily signing below, I show that I have read, or have read to me, the above consent to treatment, have been told about the benefits and risks of the above procedures, and have had an opportunity to ask questions. 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.

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Patient Signature Date (relation to patient if not self)
(or patient representative)

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Office Signature Date