LEVIN 道 THERAPEUTICS

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PEDIATRIC CONSENT FORM

Notice of Patient's Rights and Responsibilities of The Health Care Practitioner

Each parent / legal guardian and minor patient who visits this office for care is entitled to receive the information they need to understand the nature of acupuncture-based care and treatment for their health condition. This includes what to expect during the intake interview, the elements of an acupuncture- specific physical examination, an explanation of the proposed treatment methods, the potential positive benefits as well as potential negative or adverse effects, the anticipated frequency and duration of treatment, and the fees associated with care. It is your right as a parent / guardian to have your questions answered in a clear, understandable and respectful manner. Your child has the right to receive information in a developmentally appropriate manner.

Your right, and the right of your child, to privacy with respect to medical and health information must be upheld, as detailed in the separate notice of your rights under HIPAA (Health Insurance Portability and Accountability Act of 1996). Your child's medical and health information will be treated as confidential, except as otherwise provided by law. Your right to seek consultation with other health care professionals concerning your child's care is to be respected and facilitated as appropriate. As set forth in Pennsylvania law, you and your child have the right to receive care in a safe setting, free from all forms of abuse or unprofessional behavior. Complaints should be reported to the State Board of Medicine, P.O. Box 2649, Harrisburg, PA 171052649; phone: (717) 783-1400; fax: (717) 787-7769.

Please note: this practitioner does not participate in third party insurance plans. Upon request, you will be provided a Super Bill documenting your coded diagnosis, treatment and payment for service. It is your responsibility to submit this document to your insurer if reimbursement for care is possible.

Acknowledgment:

I have read and understand the above statement detailing my Patient's Rights / Minor Patient's Rights and the responsibilities of the health care practitioner (Brenda Levin, L.OM.)._____(please initial).

Informed Consent for Acupuncture Treatment

Acupuncture is a tradition-based healing art, informed and guided by the philosophy, observations and experiences of practitioners initially based in ancient China. Variations in clinical practice have evolved as acupuncture-based medicine spread throughout Asia, Europe and the Americas. Although scientific

evidence of acupuncture effects exists, in general, the human biological basis for acupuncture benefit is incompletely understood, and the likelihood of benefit from acupuncture can be highly individual.

The diagnostic methods of acupuncture include an intake interview to gather health and medical information, a physical examination that may include palpating the pulses at the wrist, looking at the tongue, and both inspecting and touching the arms, legs, back and torso. Treatment may include the insertion of single-use sterile needles under the skin to variable depths; application of electricity to the inserted needle, or to the skin directly using an electrode or magnet; use of ion-pumping cords; application of cold laser light energy to the surface of the skin at acupuncture points; heat in the form of a carefully positioned warming lamp; the burning of a moss called moxa at acupuncture points; warm compresses; and forms of massage (Tui-na) and stretches (Sotai) across the back, upper and lower extremities, and scalp. Cupping, Gua-sha (a more vigorous form of massage) and Shoni-shin are specific massage techniques that will be demonstrated if indicated for your care; and administered if you agree verbally to their use. Your verbal consent will be documented in the medical record. Small pellets, magnets, seeds or shallow needles may be placed at acupuncture points in order to continue point stimulation at home in the days after your treatment in the office. Additional aspects of care may include life-style and nutritional counseling, exercise and stretching recommendations, and with your HIPAA- specific written consent, discussing your care with your other health care professionals. Treatments will be modified for pediatric patients to assure comfort and safety.

In this practice environment, acupuncture and related therapies are considered complementary to the standard Western scientific medical care recommended by your personal physician. Serious medical conditions in particular should be managed by your physicians. It is your responsibility to obtain this care for your child. It is also your responsibility to tell your acupuncture provider (LS) if your child has a blood clotting disorder, takes an anticoagulant, is immune-compromised, has a skin infection, HIV-1 or infectious hepatitis.

Adverse reactions to acupuncture and related therapies may occur. They are uncommon and most often of minimal significance. Bleeding, bruising, a feeling of light-headedness, headache, weakness, nausea, a transient increase in pain, tingling or other abnormal sensations from sensory nerve activation, skin infection, fatigue, and aggravation of your child's presenting symptom may occur. Very rare complications of acupuncture reported in the literature include pneumothorax (abnormal location of air in the chest) or damage to a major nerve or spinal cord. Special care is taken to assure the comfort and safety of pediatric patients; for example, cold laser treatments rather than needles may be used to stimulate acupuncture points. All patients are advised to use caution when walking in bare feet, as stray needles may be on the treatment room floor.

Please acknowledge, through your dated signature below, that you have read and understood this consent document. In addition, please note that each procedure will be again explained in language that is clear to you. Every effort will also be made to explain the steps of treatment to your child. The potential risks as

well as potential benefits of the proposed treatment and procedures will be clearly stated; and that all your questions will be answered to your satisfaction before treatment begins. You have been informed and understand that you have the right to refuse any form of treatment.

Consultation with a licensed acupuncturist fully trained and experienced in herbal treatments is available to you upon request. You will be asked to provide a separate consent for treatment with herbs and/or nutritional supplements by the consulting practitioner.

Attestation of Consent

I have read, or have had read to me, the full text of this consent document. By my signature below, I agree to treatment of my child by Levin Therapeutics, LLC. I understand that there is always the possibility of an unexpected untoward reaction or complication to treatment or a procedure, and that no guarantee can be made concerning the results of his/her treatment.

I intend that this signed consent document will cover the entire course of treatment for my child's current condition, as well as any future condition(s) for which my child might seek acupuncture treatment from Brenda Levin, L.OM.

Parent signature:_____for (child) _____

Printed parent name:_____Date: _____

I understand that it may be necessary for Brenda Levin, L.OM. or a staff member to contact my child's primary care physician or other health care provider in order to discuss an emergency situation; or to share medical information that is critically important to assure his/her safety. By my signature below, I consent to the sharing of my child's medical information under these circumstances and understand that I will be asked to sign a separate form to authorize non-emergent communication with my child's health care providers.

Signed: _____ Date: _____