NUMINOSITY
a center for wellness

Informed consent for routine clinic services (excludes psychotherapy)

***Patient Name**: _____*

Please initial and date the following consents for services received.

_____**CONSENT TO ROUTINE ACUPUNCTURE SERVICES:** I consent to the services to be rendered during this visit on an outpatient basis by Molly Green, LAC and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named above. I understand and am informed that, as in the practice of all medicine, in the practice of acupuncture, there are some risks including but not limited to bruising, bleeding, blistering, pneumothorax, or fainting. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interests. I understand that no guarantee has been made to me as to the result or cures that may be obtained from examination or treatment in this clinic. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I may seek treatment.

_____**CONSENT TO ROUTINE CHIROPRACTIC SERVICES:** I consent to the services to be rendered during this visit on an outpatient basis by Korin Rasmussen, DC and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named above. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to chiropractic manipulative therapy, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. I understand that no guarantee has been made to me as to the result or cures that may be obtained from examination or treatment in this clinic. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I may seek treatment.

_____**CONSENT TO ROUTINE MASSAGE SERVICES:** I consent to the services to be rendered during this visit on an outpatient basis by Lyn Hughey or Gina C. James and/or other licensed massage therapists who now or in the future treat me while employed by, working or associated with or serving as back-up for the massage therapist named above. I understand and am informed that, in the practice of massage therapy there are some risks to treatment, including but not limited to sore muscles and joints, increased risk of emboli from varicose veins, and increased blood pressure from hypertension. I do not expect the massage therapist to be able to anticipate and explain all risks and complications, and I wish to rely on the massage therapist to exercise judgment during the course of the procedure which the massage therapist feels at the time, based upon the facts then known, is in my best interests. I understand that no guarantee has been made to me as to the result or cures that may be obtained from treatment in this clinic. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I may seek treatment.

_____**CONSENT TO ROUTINE NATUROPATHIC SERVICES:** I consent to the services to be rendered during this visit on an outpatient basis by the doctor of naturopathic named above and/or other licensed doctors of naturopathic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of naturopathic named above. I understand and am informed that, as in the practice of other medicine, there are some risks to naturopathic therapies. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of procedures and therapies which the doctor feels at the time, based upon the facts then known, is in my best interests. I understand that homeopathic, nutritional and herbal therapy is administered in an attempt to improve body function, to strengthen health, and thus increase resistance to environmental stresses and diseases. I have been informed that Mona Bhalla, ND strives to provide and/or recommend only the highest quality products for her clients. I will not hold Mona Bhalla, ND responsible for any adverse reactions due to the quality or manufacturing of any products prescribed by her to me. I understand that no guarantee has been made to me as to the result or cures that may be obtained from examination or treatment in this clinic. 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 may seek treatment.

I, OR MY REPRESENTATIVE, HAVE READ, FULLY UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS. I HAVE RECEIVED A COPY OF THIS INFORMATION.

_____ _____ _____ _____
Signature of Patient Date Signature of Insured/Agent Date

If patient is under the age of 18, or is otherwise unable to sign, please complete the following:
Patient is _____ years of age OR unable to sign because: _____

_____ _____ _____
Signature Date Relationship to patient

Gina c. James, LMT, #7348 | Korin Rasmussen, DC, LLC | Christina O. Rose, LPC, LLC
Mona Bhalla, ND, LLC | Molly Green, L.ac | Lyn Hughey, LMT, #5191
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