INFORMED CONSENT TO ORIENTAL MEDICAL HEALTH CARE,
NOTIFICATION REGARDING PHYSICIAN'S EVALUATION OF PATIENT,
and
ACKNOWLEDGMENT OF RECEIPT OF PAYMENT AND PRIVACY POLICIES

Informed Consent for Treatment

I hereby request and consent to the performance of the following procedures on myself (or on the patient named below, for whom I am legally responsible) by Janice A. Olsen, RN, CNM, L.Ac., dba EastWest Women's Health ("Jan Olsen"): (i) acupuncture and other oriental medical procedures including diagnostic techniques such as pulse evaluation, palpation on a variety of areas of my body, observation, questioning, range of motion, muscle and orthopedic testing; (ii) modes of manual or physical therapy such as massage, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation; (iii) the prescription of herbal and homeopathic medicines as well as dietary supplements; (iv) dietary recommendations; and/or (v) exercise advice and healthy lifestyle counseling.

I have had an opportunity to discuss with Jan Olsen the nature and purpose of acupuncture and oriental medical procedures. Although I am aware that acupuncture and other procedures used in oriental medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition has been given or implied. I understand and am informed that, as in the practice of traditional Western medicine, the practice of oriental medicine may involve some risks to treatment. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, pneumothorax, puncture of other organs, pain or other strong sensation at the location of symptoms, appearance of new symptoms, general aches, sprains, strains, dislocation, fractures, disc injuries and strokes.

I do not expect Jan Olsen to be able to anticipate and explain all risks and complications, and I wish to rely the practitioner to exercise such judgment, during the course of my treatment, as the practitioner feels at the time, based the facts then known, to be in my best interest. I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask questions about its content and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment from Jan Olsen.

I understand that if Jan Olsen refers me to a health care provider, it is my responsibility and choice to follow this advice.

Notification of Physician's Evaluation

I recognize that I should be evaluated by a physician for the condition that Jan Olsen is treating me for, and I hereby notify Jan Olsen that I ☐have ☐have not been so evaluated by a physician, dentist or nurse practitioner within the last six months.

Acknowledgment of Receipt of Privacy and Payment Policies

I hereby acknowledge that I have been provided Jan Olsen's HIPAA, privacy, and payment policies, either by access to the EastWestWomensHealth.com site or in printed form.

Patient's name (please print)	*Date signed*
Patient's signature	*Signature of Witness*