CLIENT CONSENT FORM

I hereby attest to the following:

1. Services provided by No Allergies Please® ("PRACTITIONER") may include, but are not limited to:

Sensitivity testing	Chinese Tuina Massage	Gua Sha	NET (Neuro Emotional Technique
Acupuncture/Acupressure	Cosmetic Acupuncture	Nutritional Coaching	Cupping or Moxibustion

   Before any of these procedures are performed, PRACTITIONER will discuss my treatment options and only proceed if my consent is given.
2. My PRACTITIONER has informed me of the risks and symptoms of treatment, which can include, but are not limited to: slight pain, light-headedness or nausea, soreness, bruising, bleeding or discolouration of the skin, and the possibility of other unforeseen risks. I freely accept the risks involved with my procedure. Cosmetic acupuncture cannot predict the actual outcome or how long the effects will last. I understand that I do not have any of the contraindications for Cosmetic Acupuncture as mentioned by the PRACTITIONER.
3. I will inform my PRACTITIONER if I currently have or develop any major health issues, if I suffer from any type of major bleeding disorder, or if I use a pacemaker.
4. I understand that I must let PRACTITIONER know if I am carrying, or believe to have any infectious agents, including but not limited to HIV, TB and Hepatitis. In some cases where cross-infection is high, PRACTITIONER may withhold treatment.
5. I understand that there are no guarantees for the results on my treatments. Traditional Chinese Medicine does not often provide an instant cure. The length of my treatment depends on the severity of my condition. In some cases symptoms may temporarily worsen before they begin to improve.
6. I understand that the fees charged for my treatment are not covered under OHIP and must be covered in full by myself or through third party insurance. I am responsible for the full and prompt payment after services have been rendered.
7. The PRACTITIONER(s) are not medical doctors and do not use medical diagnostic or treatment procedures.
8. The services performed by the PRACTITIONER are at all times restricted to consultation on the subject of nutritional matters or the sensitivities to various substances, and does not involve the use of scratch tests, needles or blood tests to verify my sensitivities, allergies or intolerances to foods or environmental substances. All testing is done for experimental or educational purposes only and does not involve the diagnosing, curing, prognosticating, treatment or prescribing of remedies for the treatment of disease or any act, which will constitute the practice of medicine in this province in which a license is required.
9. The decision to follow any recommendations rests solely with me (the undersigned). Program compliance is required for maximum results.
10. I should not for any reason, ingest or expose myself to any substance that I have previously been diagnosed as highly allergic or anaphylactic by a qualified medical physician/allergist unless I have first been given consent by a qualified physician/allergist.
11. I understand that all suggestions (if any) regarding herbs or nutritional matters are based on historical and traditional use and are not intended to diagnose, treat, cure or prevent any disease. If I am pregnant, nursing, diabetic, on medication, have a medical condition, or are beginning a weight control program, I will consult with my physician before using any recommended product or making any other dietary changes. I will discontinue use if an allergic reaction occurs.
12. Any supplements I prepay for will be discarded if not picked up within 90 days of purchase. There is no refund for opened supplements.
13. I understand that the testimonials presented apply only to the individuals depicted, cannot be guaranteed, and should not be considered typical.
14. I understand that as with any health or fitness program, a sensible eating plan, proper sleep, stress management and regular exercise are required in order to achieve long-term results.
15. I agree to indemnify and keep PRACTITIONER and her agents indemnified from and against all loss, actions, suits, judgments, costs, expenses, fees, claims, damages or liabilities suffered or incurred in connection with a breach of this Client Consent Form by me.
16. PRACTITIONER will not be liable to me for any costs, loss or damages unless due to the failure of PRACTITIONER to perform services as agreed. I further understand and agree that in no circumstance whatsoever shall liability of PRACTITIONER to me exceed the sums paid by me in respect of the particulars services provided by PRACTITIONER to me.
17. I understand that any information provided is for general purposes only and designed to help me make informed decisions about my health. It is not intended to substitute advice from my physician or health-care professional.
18. The statements (appearing on this document) have not been evaluated by the Food and Drug Administration or Health Canada.
19. PRACTITIONER requires 24 hour notice for appointment cancellation. Appointments cancelled within the 24 hour period will incur a charge of 1⁄2 the hourly rate. No shows will be charged in full. PRACTITIONER reserves the right to charge for missed appointments. I understand and agree to abide by this cancellation policy.
20. I have discussed the content of this form with PRACTITIONER. I acknowledge that I have asked any questions I may have and received answers that I understand. By signing this form, I give my informed consent for Traditional Chinese Medicine treatments.

Client Name: **DOB(mm/dd/yyyy):**

Address: **City:** **Prov:** **Postal Code:**

Email:

Main Phone: **Referred by:**

Emergency Contact: **Emerg Phone:**

Add me to your email list for newsletter/communication purposes (circle one): ***Yes*** ***No***

Signed*: **Date:**

* Parent or Guardian if client is under the age of 18

(**CONTINUED ON OTHER SIDE**)

For office use only: ☐ QB ☐ AW

CLIENT CONSENT FORM
Consent to Collect and Release Information

I _____ □ Consent □ Do not consent
(Print name)

For Clinic No Allergies PleaseTM to collect and release my general patient or medical information to other medical practitioners or health care providers/support workers, emergency personnel and/or any other relevant organizations.

In terms of information, the Clinic may collect any of the following:
- Contact information
- Personal or family medical history
- Medical insurance or billing/account information

In cases of emergencies or life-threatening situations, medical or support staff workers may have to collect this information from family members or other listed contacts without your prior written consent.

How Your Information Will Be Used

Your personal information can be used or disclosed for the following reasons:
- For billing or account purposes
- To assist 3rd party insurance companies with insurance claims
- Referring your medical history to another health practitioner or health care provider
- To seek advice for potential treatment options
- To prevent or assist patients in cases of emergency or threats to their health and safety
- To fulfill any obligations as mandated by law

Patient Access to Information

I understand that my personal and medical history is available to me for my review under most circumstances. Cases where access to records can be limited are:
- In cases where access to information causes a threat to your life or personal health
- Where the law disallows access to information
- In the event where disclosure of information relates to any anticipated or actual legal proceedings or professional conduct proceedings.

Acknowledgment

I allow for medical personnel to use and disclose my information as outline above.
I understand that I can access my personal health information except as outlined above.
I understand that I can withdraw my consent at any time, but it may directly affect the services I can receive. My personal information can still be used/disclosed if mandated by law.

Additional Comments or Restrictions:

_____

_____

_____

Patient signature: _____ Date: _____

Witnessed: _____ Date: _____