Wealth of Health Center

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PATIENT INFORMED CONSENT

I,______________________________hereby request and consent to the performance of acupuncture and related modalities on me (or on the patient listed below for whom I am legally responsible) administered by the acupuncture physician listed below, whether the treatment is performed at the clinic which may be listed below or at some other location.

I understand that the methods of treatment may include, but are not limited to acupuncture, electro-acupuncture, biofeedback, bioenergetics assessment, electro-therapy, Trinfinity 8, Electronic Gem Therapy, applied kinesiology and natural internal medicines, which may include herbs, minerals, animal by-product, homeopathic dilutions and nutritional supplements, which may be administered for oral consumption or topical application and may be in the form of, pills, powders, tinctures or sterile indictable. I understand the assessment tools such as LSA are energy assessment tools and are not to be taken as a diagnosis. They are an energetic evaluation to help establish the focus of the prevention of them becoming disease. I also agree to being attuned to light therapy devices and energizing devices that are not FDA approved and make no claims to treat or cure disease.

I agree to report any unanticipated or disturbing effects associated with the consumption of these medicines or modalities. I understand that it is my responsibility to inform my physician of any and *all* other medications that I am taking so that any untoward interactions can be avoided. Although negative interactions are rare, I do understand that the correct medical knowledge concerning interactions of prescription pharmaceuticals with herbs and other natural supplements is incomplete. I understand that the choices of my food drink, smoking and drinking coffee and alcohol may affect the healing response. I agree to communicate these activities as well with the side effects I experience and report. I understand that drinking plenty of water and getting rest, following a low carb, high protein diet are an essential part of safe recovery of health. I understand when toxins are leaving my cells I may need further treatments to assist in the removal as the Detox pathways may become blocked. It is my responsibility to notify Dr. Koger early about the Detox response I am having so appropriate steps can be taken.

I have been informed that acupuncture and its related modalities are a safe method of treatment with few and infrequent side effects. The side effects may include bruising, temporary numbness or tingling near the needle sites, temporary lightheadedness which may last for an hour or more, or fainting due to "needle shock". My practice complies with the highest industry standards and legal requirements by using only pre-sterilized disposable needles and maintaining a clean and safe working environment I understand that this document describes only the known and major risks and possible side effects known major risks and possible side effects of Acupuncture and related treatments. The herbs and other nutritional supplements that are used in my practice are considered
Safe but may be toxic if consumed in large doses. Some supplements may be contraindicated during pregnancy. I understand that I must carefully follow the acupuncture physician's instructions regarding dosage and other usage parameters. I further understand that I must inform my acupuncture physician if I am or become pregnant.
Dr. Koger uses the latest Medical Biofeedback analysis to optimize results The scans are energetic assessments and not to be considered a diagnosis.

I understand that positive results of treatment are not guaranteed. I understand that all my medical records will be kept confidential and will not be copied or viewed by others without my express written consent, except as may be required by legal mandate.

By voluntarily signing this form, I am indicating that I have read (or had read to me) this "Consent to Treatment' and have had the opportunity to ask questions about any concerns. I intend this consent to cover the entire course of treatment for my present condition and for any future conditions for which I might seek treatment from this Acupuncture Physician.

Date:______________________

PATIENT'S NAME:
Please print name.---

Relationship to patient:_______________

Patient Signature---
(or legal representative)