Addendum-Adult:
Informed Consent for Integrative Healthcare

Groff & Associates, LLC is committed to provide quality, professional healthcare to all of our clients (client is referred to as "I", "me" or "my" herein). Integrative healthcare services, including but not limited to acupuncture treatment, Biosound Therapy, and/or dietetic services involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. This addendum modifies the agreement and Consent between Client and Groff & Associates, LLC., who acknowledge and agree that this Addendum is incorporated into and made a part of the agreement and Consent initially signed by Client, the terms and provisions of which, except as expressly modified in this Addendum, are hereby affirmed and ratified.

Integrative healthcare is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist and pregnant clients are also being managed by an appropriate healthcare professional, and clients seeking adjunctive cancer support are also under the care of an oncologist. I understand the integrative healthcare may be discontinued at any time by either party. The Agency encourages this decision be discussed with the healthcare clinician. This will help facilitate a more appropriate plan for discharge.

I hereby request and consent to the performance of integrative healthcare services (or on the client named, for whom I am legally responsible) by the healthcare clinician providing services to me now and in the future.

Specific Informed Consent/Specific Modalities and/or Services:

Acupuncture Treatment:
I understand acupuncture treatment is being provided by an Indiana State Licensed Acupuncturist. I understand methods of treatment may include, by are not limited to: acupuncture, moxibustion, cupping, and nutritional counseling. I appreciate it is not possible to consider every possible complication to care.

I have been informed acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat. Bruising is a common side effect with cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the Agency uses sterile disposable needles and maintain a clean and safe environment.

I understand while this document describes the major risks of treatment, other side effects and risks may occur. I will notify the acupuncturist who is caring for me if I am, or become, pregnant or if I am nursing.

While I do not expect the acupuncturist to be able to anticipate and explain all the possible risks and complications of treatment, I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, and is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this Agency of any medical history, family history, medications, and/or nutritional supplements being taken currently (prescription and over-the-counter). I understand the

Clinical Director, acupuncturist, and administrative staff may review my client records and possible lab reports, but all my records will be kept confidential and will not be released outside of the Agency without my written consent.
I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

Biosound Therapy:

I understand Biosound Therapy is being provided by an Indiana State Licensed Mental Health Counselor (LMHC). Biosound Therapy is not intended to be a substitute for any diagnosis or to be used as an alternative to necessary physical or mental healthcare. I understand Biosound Therapy may be discontinued at any time by either party. I understand that I must inform and continue to fully inform this Agency of any medical or family history changes, as well as medications that are currently being taken.

I understand methods of treatment may include, but are not limited to: biofeedback, guided imagery, meditation, Solfeggio music therapy, and video content.

I appreciate it is not possible to consider every possible complication to care. I understand that Biosound Therapy can have side effects, although uncommon. I have been informed Biosound Therapy is a generally safe method of treatment, as with all types of therapeutic interventions, there are risks. Please answer the following questions:

1. Are you pregnant? Yes___ No___
2. Have you ever had a blood clot (thrombosis?) Yes___ No___
3. Have you had a recent head trauma? Yes___ No___
4. Do you have a pacemaker? Yes___ No___
5. Do you have a seizure disorder or Schizophrenia? Yes___ No___

If you answered 'Yes' to any of the questions above, you may not receive the sound vibrational massage during treatment.

______ **(Initials)** I fully understand the questions above, have answered them honestly and give my consent to receive this treatment.

I acknowledge, warrant, and represent that I have informed the Biosound clinician and any of my healthcare clinicians of any of the above conditions.

I understand while this document describes the major risks of treatment, other side effects and risks may occur. I will notify the Biosound clinician who is caring for me if I am, or become, pregnant. While I do not expect the Biosound clinician to be able to anticipate and explain all the possible risks and complications of treatment, I wish to rely on the Biosound clinician to exercise judgment during the course of treatment, which the Biosound clinician thinks at the time, based upon the facts then known, and is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand there are treatment options available for my condition other than Biosound Therapy. This may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, mental health counseling, nutritional care and medical care with/without prescription drugs. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit. I understand that I must inform, and continue to fully inform, this Agency of any medical history, family history, medications, and/or nutritional supplements being taken currently (prescription and over-the-counter). I understand the Clinical Director, Biosound

clinician, and administrative staff may review my client records and possible lab reports, but all my records will be kept confidential and will not be released outside of the Agency without my written consent.

Dietetic Services:

I understand nutritional counseling is being provided by an Indiana State Licensed and Registered Dietitian. I agree and consent to having a nutritional assessment done to evaluate my nutritional status, habits, and needs. After completing an assessment, I understand and agree my dietitian will discuss how to proceed by developing a nutritional plan with personalized and realistic goals.

I consent to having my dietitian obtain information, resources, and guidance related to my nutritional health. I understand my dietitian will not dispense medical advice, diagnose or treatment me beyond the scope of the Indiana state held license. The information provided through dietetic services is designed to meet my personal dietary needs and will not be transferred, copied, or sold to another person/organization.

I understand that it is necessary to inform my dietitian of any changes I make to my diet. It is my responsibility to report any symptoms or side effects immediately to both my primary care physician and dietitian; and to make the necessary adjustments to my treatment plan with my primary care physician and dietitian. I will not hold my dietitian responsible for for any complications that result from my failure to comply with the above.

In order for nutritional counseling to be most successful, I agree to attend regular sessions, work on making changes in-between session and to be honest with my dietitian about my behavior. It is often recommended that clients with disordered eating habits regularly participate in mental health counseling with a clinician as well as medical monitoring by a primary care physician. I understand I'm free to stop nutrition counseling at any time and I will chose to consult with my dietitian should I decide to terminate services.

For my dietitian to provide relevant and appropriate recommendations, I understand that: I must provide personal health information to the best of my ability. My personal health information will only be collected, used, or disclosed with my express or implied consent, unless a collection, use, or disclosure is permitted or required by law.

Consent:

I confirm that I have read, or have been read to me, the above consent, have been told about the risks and benefits of acupuncture treatment, Biosound Therapy, and dietetic services. I have had the opportunity to ask questions. I agree with the current or future recommendations for care. 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 seek treatment. I consent to treatment and agree to abide by the above stated policies and agreements with the Agency.

______________________________ **Signature of Client or Legal Representative**

______________________________ **Printed Name of Client or Legal Representative**

______________________________ **Printed Name of Person under Legal Guardianship**

____________________ **Date**

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