Dr. Glenn Wilcox LLC

Informed Consent to Healthcare

I hereby request and consent to the performance, now or in the future, of the following on me (or on the patient named below, for whom I am legally responsible) by Glenn Wilcox, D.O.M.: acupuncture and other oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, manual palpation on a variety of areas of my body, range of motion evaluation, muscle, orthopedic and neurological testing; various physical medicine modalities and therapeutic procedures such as massage, manipulation of joints and structures, heat and cold therapy and electrical or magnetic stimulation; the prescription of herbal and homeopathic medicines as well as dietary or nutritional supplements and other natural health care products and devices; dietary recommendations; advise regarding exercise regimens; lifestyle counseling; and the following oriental medicine expanded practice and prescriptive authority procedures and prescriptions for which I understand Dr. Wilcox is certified by the New Mexico Board of Acupuncture and Oriental Medicine: injection therapy; intravenous therapy and the prescription of bioidentical hormones.

I understand that there are some risks associated with oriental medical treatment and that while unlikely, possible risks that have occurred as a result of treatment by Dr. Wilcox include an occasional small bruise, hematoma or spot of blood, general aches and with some conditions a temporary aggravation of symptoms. However, even though the following have **not** occurred as a result of treatment by Dr. Wilcox, other possible risks include but are not limited to: large bruises, bleeding, infections, inflammation, burns, sprains, strains, dislocations, fractures, disc injuries, strokes, puncture of organs, nerve pain and the appearance of new symptoms. I also understand that while very unlikely, it is theoretically possible for death to occur as a result of treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications during the course of treatment. I wish to rely on the doctor's judgment based on the facts known at the time. With regard to acupuncture treatment, I understand that generally I should experience no pain or discomfort. However, some vigorous needle manipulation techniques may cause a variety of sensations, which may be somewhat painful at times for some people. These sensations may occur at the location where a needle is inserted or may radiate from that location. If Dr. Wilcox plans to use such techniques on me, I understand that he will discuss this with me first and that I will have the option to decline. I also understand that the acupuncture needles are FDA approved, single use, sterilized and properly disposed of after each use.

I understand that there is no way to determine in advance exactly how many treatments may be necessary for my condition. I understand that in general the recommended treatment frequency is once or twice a week and as my condition improves treatment frequency is decreased. For some individuals and for some conditions, less or more frequent treatment will provide more satisfactory results. Since the number of treatments needed for a given condition will vary greatly depending on such factors as the individual's vitality, health history, the type of condition, the length of time the condition has existed, a person's lifestyle and many other factors, I understand that it is not possible to initially determine how many treatments I may need. However, after his initial examination and at appropriate intervals during the course of treatment, I understand that Dr. Wilcox will discuss with me what my options are with regard to treatment frequency and how many treatments I may need. I understand that although oriental medical therapies have helped millions of people, no guarantee of cure or improvement in my condition is given or implied and as Dr. Wilcox evaluates my condition he will discuss with me the possible treatment outcomes.

I understand that, should I so request at any time, I will be given an opportunity to discuss with Dr. Wilcox any questions I have regarding the nature and purpose of treatment and the potential benefits and risks of treatment. I have read, or have had read to me, this consent. I have also had an opportunity to ask questions about its content, and by signing below I consent to consultation and/or diagnostic and therapeutic procedures with Dr. Wilcox. 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 understand that I have the right, at any time, to decline a diagnostic or treatment procedure in full or in part.

_____	_____
Printed Name of Patient	Printed Name of Patient's Representative (if applicable)
_____	_____
Signature of Patient	Signature of Patient's Representative (if applicable)
_____	_____
Date Signed	Relationship of Patient's Representative (if applicable)

Revised 03/10/08

I, _____, acknowledge that I have received a copy of the

1. Notice of Privacy Practices
2. Records Retention, Release & Destruction Policy

Please initial:

_____ I give permission for Dr. Glenn Wilcox LLC to leave detailed messages on my telephone. I prefer them be left on my ____ Home ____ Cell.

_____ I give permission for Dr. Glenn Wilcox LLC to speak to _____ regarding my medical treatment.

_____ I give permission for the practitioners of Dr. Glenn Wilcox LLC to treat my minor child without my presence in the office.

_____ _____

Signature Date