



HOPKINS CLINIC FOR PHYSICAL MEDICINE

*Providing Urgent Care Medical Treatment
and Physical Therapy Rehabilitation Services*



ACUPUNCTURE CONSENT FORM

“Acupuncture” means the stimulation of a certain point or points near the surface of the body by the insertion of special needles. The purpose of acupuncture is to prevent or modify the perception of pain and is thus a form of pain control. In addition, through the normalization of physiological functions, it may also serve in the treatment of certain diseases or dysfunctions of the body. Acupuncture includes the techniques of electro-acupuncture (the therapeutic use of weak electric currents at acupuncture points), mechanical stimulation (stimulation of an acupuncture point or points on or near the surface of the body by means of apparatus or instrument), and moxibustion (the therapeutic use of thermal stimulus at acupuncture points by burning Artemisia alone or Artemisia formulations).

The potential risks: slight pain or discomfort at the site of needle insertion, infection (rare), bruises, weakness, fainting, nausea, and aggravation of problematic systems existing prior to acupuncture treatment.

The potential benefits: acupuncture may allow for the painless relief of one’s symptoms without the need for drugs, and improve balance of bodily energies leading to the prevention of illness, or the elimination of the presenting problem.

Use of Disposable Needles: To reduce the possibility of infection from acupuncture, all needles are pre-sterilized, one-time-use needles made of surgical stainless steel needles. After each treatment they are disposed of as medical waste, needles are never reused. Additionally, Dr. Hopkins has had training in and follows the procedures of Clean Needle Technique and Universal Precautions.

I understand that Dr. Hopkins has recommended acupuncture treatment for me in the capacity of a pain mediator to reduce my symptoms. No cure or promises regarding my reaction to the treatment have been made or implied.

I request and consent to the performance of the acupuncture procedure. I understand that I am free to withdraw my consent and that I may stop treatment or any procedure at any time. I understand that my signature in this form indicates that I have read and understand the preceding information regarding my treatment. I understand that if I have any questions about this information, I should ask Dr. Hopkins. I, hereby release Dr. Hopkins and Hopkins Clinic from any and all liability that may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care.

“With this knowledge, I voluntarily consent to the above procedures.”

Printed Name

Patient Signature

Witness

Date



HOPKINS CLINIC FOR PHYSICAL MEDICINE

6231 66th Street North ♦ Pinellas Park, Florida 33781

Phone 727 544 3330 ♦ Facsimile 727 544 3221

E mail address: hclinic@tampabay.rr.com ♦ Website: www.hopkinsclinic.com



TO ALL PATIENTS OF HOPKINS CLINIC

FINANCIAL DISCLOSURE

Hopkins Clinic strives to provide the highest level of services and convenience to our patients. In that regard, Susanti Chowdhury, M.D., has agreed to rent medical office space at this facility in order to treat his patients. Hopkins Clinic also refers patients to Dr. Chowdhury for medical evaluation and treatment. Dr. Chowdhury has no investment interest in Hopkins Clinic. Hopkins Clinic has no investment interest in regard to the practice of Dr. Chowdhury.

The purpose of this document is to advise all patients of Hopkins Clinic that if they are referred to Dr. Chowdhury they are free to obtain those same or similar services from another provider of the patient's choosing or request referral to another physician with the help of Hopkins Clinic.

As Dr. Chowdhury is a pain management specialist, referrals for the same or similar services can be obtained from but not limited to the following physicians:

Todd Traub, M.D.
6221 - 66th St North
Pinellas Park, FL 33781
(727) 545-8454

Charles Friedman, D.O.
6640 - 78th Avenue North, Suite A
Pinellas Park, FL 33781
(727) 518-8660

The preceding information is provided to all patients of Hopkins Clinic prior to their receipt of any services at this office. This form must be read and signed by all patients of Hopkins Clinic. A copy of this signed form is available upon your verbal request.

Printed Name

Signature

Date



HOPKINS CLINIC FOR PHYSICAL MEDICINE

*Providing Medical, Chiropractic
and Physical Therapy Rehabilitation Services*



OPEN DOOR OFFICE POLICY

Due to the nature of aesthetic and physical medicine procedures, manual “hands on” contact of a patient by the physician and/or Clinic staff during examination and treatment procedures is often required. To assure the comfort of the patient, a “GENERAL OPEN DOOR POLICY” is utilized in this office. This general policy requires that the door to the treatment room or examination room remain open at all times when the room is occupied by **ONLY ONE** employee of Hopkins Clinic and the patient.

Patients may occasionally be asked to partially disrobe for an examination or procedure. Every effort to promote and safeguard your modesty will be applied.

Situations that necessitate the door to be closed include but are not limited to:

1. The patient is partially disrobed for an examination or a procedure.
2. The treatment room door must be closed and **LOCKED** from the inside during the use of a laser. (As required by Florida Statutes for safety reasons)

When the door to the examination or treatment room is **CLOSED**, at least **TWO** employees of Hopkins Clinic **MUST** be present at all times.

If you have any questions regarding this policy, please do not hesitate to ask to personally speak to the Clinic Director, Clayton Hopkins, D.C., or any other employee of Hopkins Clinic.

I have read and understand the following office policy.

Please Print Name

Please Sign Name

Date



HOPKINS CLINIC FOR PHYSICAL MEDICINE

*Providing Chiropractic
and Physical Therapy Rehabilitation Services*



INFORMED CONSENT

I hereby authorize the physicians and/or such assistant(s) as may be selected by the physician to treat me for my current complaints and physical conditions. The physician has explained to me the findings of the examination as well as the possible procedures necessary to treat my condition(s) by the physician and/or his assistants. The possible treatment procedures may include electric muscle stimulation, ultrasound, moist heat, application of cold packs, traction, various forms of soft tissue manipulation by the doctor or a physical therapist or licensed massage therapist, acupuncture, exercise rehabilitation therapy, biomechanical and postural recommendations and lifestyle alteration. If at any time you have any questions about any procedure in this office, please be sure to ask the doctor for more information.

The possible adverse effects during and after the application of physical therapy including thermal irritation to the skin from moist heat application or cold packs, pain or soreness from therapy such as massage and exercise therapy are reviewed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interest. The very rare risk (3 per 10 million adjustments or 0.00025%)¹ of possible vertebrobasilar accident (stroke) associated with cervical manipulation is reported as is the rare possibility of major impairment (.639 per million) as a result of spinal manipulation². This has been disputed however in a review of current medical knowledge.³The anticipated benefits of treatment can be pain reduction and improvement in ability to perform activities of daily living and/or occupational activities that are now restricted due to your current medial problems. Diagnostic procedures of x-rays (if necessary) and the associated risks and benefits will also be explained to me prior to having the procedure performed.

The possible results of not seeking care and potential natural resolution of the condition(s) has been explained to me. The subject of referral to another branch of the healing arts or physician for treatment or a second opinion is discussed. The possibility of failure of these procedures to relieve pain and/or resolve my condition(s) is discussed and no guarantee to resolve the condition(s) has been made to me by the doctor or his staff. I acknowledge that I have read this document in its entirety and that I fully understand it. I acknowledge that I was given ample time to review the document and an opportunity to ask the doctor or his staff any questions I may have concerning its contents. I am also instructed to ask any questions concerning my condition(s), tests or treatment at any time in the future if such questions should arise.

Patient Name

Patient Signature

Date

Witness

¹ Hurwitz, Spine, 1996; 21(15): 1746j-1760.

² Rand Study 1996.

³ Cassidy, Spine, 2008; 33(4S): S176-S183