Third Space Wellness, LLC

CONSENT TO SERVICES

I, _____, understand that TSW Services (as defined below) are provided by Third Space Wellness, LLC ("TSW") staff and/or affiliated practitioners ("Clinicians"). I understand that this agreement covers the Clinician or Provider who initially treats me and any other Clinicians or Providers associated with TSW who may provide my treatment in the future.

I hereby give my consent to receive the following TSW Services:

A. Acupuncture Therapies

Needle Therapies: insertion of special sterilized needles or lancets at specific points or areas on the body. These services may be performed one-on-one or in-group settings.

Topical Treatments and Thermal Therapies: including, but not limited to, cupping (a technique using glass or plastic cups on the surface of the skin with a heat-created or suction-created vacuum); gua sha (rubbing on an area of the body with a blunt, round instrument); moxibustion (warming or indirect burning of mugwort on or near an acupuncture point); and dermarolling (using a small roller with microneedles on the skin).

Potential Risks: I understand that, while not common, side effects can potentially occur from acupuncture treatment. Some examples include, but are not limited to: pain, discomfort, local bruising, slight bleeding, fainting, headaches, and temporary aggravation of symptoms existing prior to treatment. Less common side effects include: spontaneous miscarriage, infection, and nerve damage and organ puncture, including lung puncture (pneumothorax). I understand that if I am pregnant it is imperative to disclose this information to my Clinician so that he or she may adjust my treatments appropriately.

B. Chinese Herbal Medicines:

Recommending therapeutic substances that include plants, minerals, vitamins, and animal materials. May be in the form of teas, pills, powders, tinctures (may contain alcohol), topical applications, suppositories, or other forms.

Potential Risks: I understand that, while not common, side effects can potentially occur from herbal medicines and dietary supplements. Some examples include, but are not limited to: headaches, skin rashes, digestive upset, or less commonly, allergic reactions to recommended herbs. I understand that if I am using herbs while pregnant or lactating it is imperative to disclose this information to my herbalist so that he or she may adjust my formulas appropriately and to disclose information about the herbs I am taking to my M.D. or D.O. who is a board certified OB-GYN and/or licensed midwife.

Herb-drug interaction: Although herbs and other supplements have the potential to interact with pharmaceuticals and certain herbs have been shown to have some effect on a limited range of pharmaceuticals, clinically significant interactions between most herbs and prescription drugs are rare or only potentially possible in theory. Nevertheless, some

prescribed drugs are very strong and have a narrow range of safe dosage, which makes any interaction more risky. It is the responsibility of the clients to disclose fully any medications currently in use, including other herbs and supplements. Clients also are expected to inform their physicians and pharmacists of any herbs or supplements they are using. Any indication that the effect of a drug is being altered by simultaneous use of an herb should be reported directly to all health professionals involved. It is also advisable to confer with your physician and/or surgeon before surgical operation, and in the event of being prescribed anticoagulants, antiepileptic drugs, and digoxin until expert advice is received.

Toxicity: All of the herbs that we use are generally considered safe and non-toxic at recommended doses for most people; however, it is important that the client use the herbs in accordance with the dosage recommended by the herbalist. As the liver and the kidneys are the body organs most vulnerable to any ingested or absorbed substance, it is also important that the client disclose to the herbalist any past or current disease in either of these organs. I understand and agree that it is important that I do not exceed the recommended dose of the herbs suggested by my herbalist. I also understand and agree to disclose to my herbalist any previous or current liver or kidney disease or related disease as well as any other condition that I believe may have an impact on my health status.

Medical Treatment: Our Clinicians are not a substitute for a medical doctor and will not suggest that I discontinue medical treatment. I understand that if I am currently under a physician's care, I should continue as long as my physician and I deem it necessary. It is my responsibility to consult with my physician before altering any prescribed medications or treatments. I understand also that if there is an emergency, or a worsening of my health condition, or if a new condition arises, that I should consult a licensed physician.

Voluntary: I hereby request and consent to receive TSW Acupuncture and Oriental Medicine Services. I have not been guaranteed any specific outcomes concerning the uses and effects of any TSW Service. I understand that I am free to discontinue any TSW Service at any time. I voluntarily assume all risks inherent in the nature of each of the TSW Services. I waive all claims, costs, liabilities, expenses and judgments against TSW and release TSW and its members, officers, agents, representatives, and employees from all claims, costs, liabilities, expenses, and judgments arising out of the TSW Service.

In-home visits: I understand that Third Space Wellness is not responsible for "slip and fall" circumstances when providing in-home services, and thus I am responsible for "slip and fall" circumstances that occur during an in-home visit.

By voluntarily signing below, I confirm that I have read, or have had read to me, and understand the above Consent to Services, have been told about and understand the risks of each of the TSW Service, and have had an opportunity to ask questions and have received satisfactory explanations. I understand that I can request more information at any time if desired. I understand that I have the right to refuse or discontinue any service any time and that this refusal may affect the expected results I am seeking. I intend this consent form to cover the entire course of treatment for my present condition and/or my

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current wellness goals, as well as for any future condition(s) and/or goals for which I seek these services.

PLEASE PRINT:

Print Patient Name	Patient Birth Date
Street Address	City, State and Zip Code
Email Address	Preferred Phone Number
Emergency Contact Name	Emergency Contact Phone Number
Signature (or parent or guardian signature if client is a minor)	Today's Date

☐ Please exclude me from your e-newsletter.*
We do not sell our mailing list.

**Note: We may still use your email address to send you health-related emails pertinent to treatment or updates from your practitioner.*

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