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Voluntary

I hereby consent to be treated by acupuncture. The procedures involved in this treatment have been explained to me. I understand I may be treated with the insertion of needles and/or with the application of heat to the skin.

I have not been guaranteed any success concerning the uses and effects of acupuncture. I understand that I am free to discontinue treatment at any time.

Possible Side Effects/Healing Reactions

I understand that acupuncture may result in certain side effects, including local bruising, slight bleeding, fainting, temporary pain or discomfort, and temporary aggravation of symptoms existing prior to treatment. Conventional medical therapy may also be indicated, either in response to an emergency or as deemed necessary in the discretion of a licensed physician.

Medical Referral

I understand that if there is a worsening of my ailment or condition, or if it does not improve within the time estimated by the acupuncturist at the beginning of treatment, or if a new ailment or condition arises, that I should consult a licensed physician.

Infectious Disease/Clean Needle Procedures

I understand that there is infectious disease carried through the air, through physical contact, and through body fluids. I understand that my practitioner follows universally prescribed precautions to guard against the spread of infection.

In the case of airborne infectious disease, such as colds and influenza, I understand that my practitioner washes her hands before seeing each patient to guard against contagion by contact.

In the case of blood-borne infections, such as hepatitis or HIV, I understand that my practitioner follows strict precautions. She uses only sterilized, prepackaged, disposable needles. Needles that are used for my treatment are used only on me, and are inserted according to clean procedures based on nationally prescribed standards.

I understand that my questions about the safety of acupuncture and the precautions taken by my practitioner are most welcome and will be answered as fully as possible.

Cancellation Policy

I understand that this office requires at least 24 hours notice for the cancellation of an appointment. Without this notice, barring an emergency, the full treatment fee will be incurred. I also understand that the full fee of $75 is charged if I fail to show for the appointment with no notice.

I have read this form carefully. I have felt free to ask any questions regarding this process, and it has been satisfactorily explained to me.

_____ _____

Print name of patient Date

_____

Signed by patient or guardian