

Information and Consent to Services

Voluntary Participation

I hereby voluntarily consent to acupuncture treatment. I acknowledge that the purposes, goals, techniques, procedures, limitations, potential risks and benefits of the service to be performed have been explained to me. I understand that I am free to discontinue services at any time.

Services To Be Provided

I understand that acupuncture serves individuals with a wide range of complaints including both acute and chronic health issues. I understand that I may be treated with the insertion of needles and/or with the application of heat to the skin.

Risk/Possible Side Effects

I understand that acupuncture may result in certain side effects, including local bruising, slight bleeding, fainting, temporary pain and discomfort and temporary aggravation of symptoms existing prior to treatment.

Infectious Disease Prevention

I understand that infectious diseases are carried through the air, through physical contact and through body fluids. I understand that my practitioner follow universally prescribed precautions and procedures (such as clean needle technique and hand washing) to prevent the spread of disease.

Client Responsibilities

I understand that it is my responsibility as a client to inform my practitioner about all aspects of my health and that, as service progresses, to inform my practitioner of changes that occur. If I experience any pain, discomfort or possible adverse side effects, it is my responsibility to immediately notify my practitioner.

Fees and Charges

I have been informed of the fees for service and I understand that payment is due at time of service. I also understand, I must give at least 24 hours notice when canceling an appointment. If I fail to give proper notification, I will be responsible for a \$50.00 "no show" or "failure to give sufficient notice fee". Initial X_____

Insurances

I give permission for my practitioner to share treatment information with my insurance company if requested to receive payment. I understand I am responsible for any fees not covered by insurance and my co-pay (due at the time of service).

X _____
Print name of client

X _____
Signature of client or guardian

X _____
Date