



Informed Consent for Acupuncture Care

Please Read Carefully

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, as necessary, including moxibustion, cupping, and/or electro acupuncture by the above-named doctor or another duly authorized doctor in the clinic.

I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.

I have been advised that only pre-sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of the treatment which the doctor feels at the time, based upon the facts then known, is in my best interests. I understand that the results are not guaranteed.

I have read this consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above mentioned acupuncture procedures. I intend this consent form to cover the entire course of treatment for my present and future conditions for which I seek treatment.

N.B. Female Patients:

I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible. I hereby state that I am not pregnant, nor is there any possibility that I may be pregnant.

READ BEFORE SIGNING

Date Signed

Print Patient's Name

**Signature of Patient
 (or parent/guardian)**

CONSENT FOR THE COST OF SERVICES

I understand that I am responsible to pay the fees for chiropractic care I receive at each session. Fees are due at the end of your appointment once services are rendered. If your treatment is billed as an insurance claim and your claim is denied, you will be responsible for payment for all services rendered. A re-evaluation will be completed every 18th visit or when the chiropractor determines that it is necessary. The fees for treatment are:

	<u>Initial Consult</u>	<u>Subsequent</u>	<u>Re-Evaluation</u>
Adults	\$80	\$55	\$65
Children (12 & under)	\$65	\$40	\$45

There is a \$30 fee for missing any appointment without notifying our office 24 hours prior to appointment time. Payment of this fee will be expected at your next appointment.

Date Signed

Print Patient's Name

**Signature of Patient
 (or parent/guardian)**

Date Signed

Print Witness Name

Signature of Witness