CONSENT TO TREATMENT AND FINANCIAL POLICY

I hereby request and consent to the performance of acupuncture and other Oriental medicine procedures on me by the licensed acupuncturist named below.

I understand that methods or treatments may include but are not limited to acupuncture, moxibustion, gua sha, and Chinese herbal medicine.

Chinese herbs [from plant, mineral, and animal sources] that may be recommended are traditionally considered safe in the practice of Chinese medicine. I understand the same herbs may be inappropriate during pregnancy and will immediately inform my practitioner if I become pregnant. I understand that herbs may cause minor gastrointestinal discomfort, bowel changes, or other effects, and if any such situation occurs I will notify my practitioner immediately.

I understand that there may be minor side effects resulting from acupuncture treatment, including but not limited to slight bleeding or bruising, lightheadedness, or drowsiness. I understand that there is always a possibility of an unexpected complication that my practitioner may not be able to anticipate.

I understand that no guarantee can be made concerning the results of treatment.

In a very small percentage of patients, symptoms may become worse for 24-48 hours before improvement. This is called The Law of Cure. Please advise your practitioner if worsening of symptoms continues for more than 2 days, and please call at any time if you have any concerns about treatment effects.

I understand that I have the right to refuse any form of treatment at any time.

I have read this form and agree to its contents, and I have asked any questions I wish to. By signing, I intend this consent form to cover the entire course of treatment for my present condition and for any future condition[s] for which I seek treatment.

Financial Policy

I understand that payment is due at the time of service. **I agree to pay the full charge for any missed or forgotten appointments without cancellation of more than 24 hours, except in cases of emergency.**

Patient Name Printed _____

Patient Signature _____

Date _____