**Naturopathic Health Center, PLLC**

**2625 Parkmont Lane SW, Olympia, WA 98502**

**Tel: 360 878 8735**

**COMMUNITY ACUPUNCTURE CONSENT FORM**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give my consent to receive acupuncture treatments performed by Dr. Preeta Kuhlman, licensed acupuncturist (license #AC61530071) at Naturopathic Health Center. Acupuncture will be applied to any of the following areas of the body: head, face, neck, ears, shoulders, elbows to fingers, knees to toes. Other Eastern modalities are not offered in this community setting.

I understand that acupuncture involves the insertion of fine needles at specific points on the body. Each needle is a single-use sterile disposable needle to maintain safety and to reduce infection. Acupuncture is generally considered to be safe, but I am aware that there may be unwanted effects such as pain, bruising, bleeding, dizziness and sometimes fainting. I will immediately notify Dr. Preeta if I am experiencing any unpleasant effects.

I understand that Dr. Preeta will insert and remove all the needles herself. I am not to remove my own needles for any reason, doing so may result in immediate termination from the clinic.

I understand that that this is a community setting. The purpose of this setting is to allow multiple people to access treatment at a reduced cost. There will be other people around me, I will respect them and be quiet during the treatment session. No cell phone usage is allowed.

I understand that acupuncture is a process, and best results are found with regular treatments as recommended by Dr. Preeta based on my individual concerns. I will ask if I have questions about acupuncture in general and specific to my treatments.

I will notify Dr. Preeta if I am pregnant, am on blood thinner medications or have experienced dizziness lately.

I understand that payment is due prior to, or at time of service. My insurance will not be billed.

I understand that my records will be kept confidential and will not be released without my prior consent.

I verify I am 18 years or older. I have read this information and had the opportunity to ask questions. By signing below, I give consent to receive acupuncture as treatment for my health concerns and wellness.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_