Blue Valley Acupuncture LLC
Acupuncture Consent to Treat

I, the undersigned, consent to treatment by the Licensed Acupuncturists at Blue Valley Acupuncture LLC (BVA). Such treatment may include acupuncture, herbal medicines, cupping, electro-stimulation of acupuncture points, and other modalities commonly and collectively referred to under the name of Acupuncture. I fully understand that there is no implied guarantee of success or effectiveness of a specific treatment or series of treatments.

If I am a cancer patient, I understand any work done at this clinic is considered adjunct to chemotherapy and/or radiation. I understand the care provided at Blue Valley Acupuncture LLC is solely supportive in nature and has nothing to do with treating cancer, but to provide the body support, symptom and/or pain relief.

The number of treatments potentially needed for your individual condition, and how that will be determined will be discussed at the initial visit and there is no number of treatments that can be guaranteed.

While this is not always the case, there is a possibility of pain, discomfort, a bruise or bleeding from needle insertion or cupping.

I understand that if I am more than 15 minutes late for an appointment, I may be asked to reschedule my appointment. Further, if I fail to cancel an appointment with at least 24 hours notice, I understand I may be charged a fee not to exceed the cost of that appointment.

I understand and agree that health and accidental insurance policies are an arrangement between the insurance carrier and myself. I understand that BVA can provide any necessary statement and treatment reports to assist me in collecting from the insurance company if payment/reimbursement is applicable to my situation. I hereby grant BVA permission to release any records requested by my insurance carrier.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. Payment is due at the time services are rendered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

By signing below, I acknowledge that I can read and understand English, that I have read and understood the above conditions and policies and agree to the same.

_____ _____

Patient's signature (or legal guardian) Date