**I hereby request and consent to the performance of acupuncture treatments and other complementary medicine procedures such as infared heat, Gua Sha, moxibustion, cupping, electrical stimulation and nutritional counseling on me (or on the patient named below, for whom I am legally responsible) by Kathy Manning, licensed acupuncturist, and/or other licensed acupuncturist who now or in the future treats me while employed by, working or associated with or serving as a back-up for Kathy Manning.**

**I have had the opportunity to discuss with Kathy Manning the nature and purpose of acupuncture treatments and other procedures. Acupuncture attempts to normalize physiological functions, to modify and lessen pain syndromes and to treat certain dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needle sites that lasts a few days. Burns and/or scarring are a potential risk of moxibustion. There have been very rare instances reported of spontaneous miscarriage and pneumothorax. Discoloration and redness of the tissues after cupping and Gua Sha are common, as these techniques move blood closer to the surface of the skin, but this should not be confused with bruising. Aggravation of symptoms existing prior to treatment may temporarily**

**occur.**

**I will inform the acupuncturist if I become pregnant, suspect that I am pregnant or are attempting to become pregnant as some treatment methods may be inappropriate during pregnancy.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Patient Name (or Guardian)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient (or Guardian)**

**An acupuncturist is not a substitute for a medical doctor and will not suggest the ceasing of medical treatment. It is my responsibility to consult with my physician before altering any prescribed medications or treatments. I understand that if there is an emergency, or a worsening of my condition, or if a new condition arises, that I should consult a licensed physician.**

**I do not expect the acupuncturist to be able to anticipate and explain all risks and complications of treatment. I wish to rely on the acupuncturist to exercise judgment during the course of treatment undertaken and to modify treatment based upon the facts known about my case. All of my records will be kept confidential and will not be released without my written consent.**

**I have been informed of and agree to the fees for service, and I understand that payment is due when the services are provided. If I do not cancel an appointment by phone at least 24 hours in advance, then I am liable for a $30.00 penalty fee. I understand that I will pay a $30.00 fee for any returned checks.**

**I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content.**

**By signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and or any future condition(s) for which I seek treatment.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date**