INFORMED CONSENT TO ACUPUNCTURE TREATMENT

I, the undersigned, do hereby give my voluntary consent for the administrating of medical acupuncture and other ancillary techniques as deemed appropriate by my treating practitioner. Ancillary techniques of acupuncture may include *electro-acupuncture*, where needles are electrically stimulated at various frequencies to increase the therapeutic benefit.

Acupuncture has been explained to me as a therapeutic treatment performed by the insertion of **single use**, **sterile**, **disposable needles**. The needles are inserted through the skin, into the underlying muscles and tissues at specific points on the body for the purpose of alleviating pain, relieving pressure on nerves, improving mobility, and re-establishing normal function.

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, fatigue, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.

I further state that the following **DO NOT** exist in my current state of health and I will immediately notify the practitioner of any changes:

- Pregnancy
- Local infections
- Pacemaker
- Anti-coagulants
- Bleeding disorders
- Elevated risk of infection
- Blood-borne infections (HIV/AIDS, hepatitis B, hepatitis C)

I do not expect the acupuncture practitioner to be able to anticipate and explain all possible risks and complications. I wish to rely on the practitioner to exercise proper judgement during the course of treatment to make decisions based upon my best interests. I accept the fact that there is no guarantee of the effectiveness of the treatment.

I hereby certify that I have read the above information and have had my questions answered to my satisfaction. By signing below, I agree to the above-mentioned acupuncture procedures.

DATE **CLIENT NAME (PRINT)** **CLIENT SIGNATURE**

MISSED APPOINTMENT / CANCELLATION POLICY

Your appointment time is reserved especially for you. If you are unable to keep your allotted time, we kindly ask that you give us a minimum of **24 hour advance notice** in order for us to give our therapists a reasonable amount of time to fill the appointment slot.

Because our therapists get affected directly when appointments are missed, or when appointments are cancelled with less than 24 hour notice, we will charge the full price of the time booked. This amount must be paid prior to your next scheduled appointment.

If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of treatment actually given, **you will be responsible for the full session**.

Please understand that appointment reminders are a courtesy. In the event that we were unable to contact you, you are still responsible for showing up at your allotted treatment time. Our therapists also gratefully respect you and your time. We understand that all our patients have busy lives and, as such, our therapists will make sure that all appointments begin and end on time.

I HAVE READ, UNDERSTOOD, and AGREE to the above policy.

DATE **CLIENT NAME (PRINT)** **CLIENT SIGNATURE**

DATE **WITNESS**