Consent to Treatment

I, (print full name)_____, voluntarily consent to be treated with acupuncture. I understand that the acupuncture will be performed by the insertion of sterile, disposable needles through the skin, or by the application of heat, or by some combination of the foregoing, at certain points on my body, and that such treatment is intended to improve body function and relieve pain.

I have been informed that although rare, side effects may result from my acupuncture treatment. These could include some minor pain or discomfort, localized bruising, fainting, nausea and the temporary aggravation of pre-existing conditions.

I accept that no guarantee is made concerning the results of my acupuncture treatment, and I have been informed that I may stop treatment at any time.

Release of Information

I (initial)_____consent to the use and disclosure of my protected health information for treatment, payment, clinic operations. Also, I have given my written consent that my health information be shared with the people, their addresses and/or contact numbers on the "Client Contact Information" form. I understand that I have the right to revoke this consent, in writing, at any time. However, the revocation will not affect any disclosures made in reliance of my prior consent.

NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS

I (initial)_____acknowledge that I have received a copy of the "Notice of Privacy Practices and Patient's Rights" and that I have had the opportunity to ask questions about it. All questions I have asked have been fully answered.

Please sign and date below pertaining to above: "Consent to Treatment", "Release of Information", and "Notice of Privacy Practices and Patient Rights".

_____ _____

Patient's Signature **Date Signed**

_____ _____

Guardian's Signature **Date Signed**