

CONSENT TO QIGONG THERAPY

I, _____, voluntarily consent to be treated with qigong therapy. I understand that such treatment is intended to improve body function and relieve pain.

I have been informed that temporary, mild side effects may result from my qigong therapy; and that I may experience the temporary aggravation of pre-existing conditions as my health and well being shifts.

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

I have also been informed that qigong therapy is not a substitute for seeking out appropriate medical advice and treatment from my physician or psychotherapist. Moreover, I understand that I should continue all medication and treatment that has been prescribed by my doctor or psychiatrist for any currently existing condition.

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 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.

Patient's Signature

Date Signed

Guardian's Signature

Date Signed