CONSENT TO THE ACUPUNCTURE TREATMENT

I here request and consent to the performance of Acupuncturist within the scope of a practical acupuncture treatment for myself (or the patient named below, for whom I am legally responsible) by a licensed Acupuncturist.

I understand that acupuncture is a safe method of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting or nerve damage. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese, Japanese medicine treatment can be very beneficial in the pregnancy and birthing process.

I have had an opportunity to discuss, with the Acupuncturist, the nature and purpose of my treatment. I understand that results are not guaranteed.

I do not expect the Acupuncturist to be able to anticipate and explain all risks and complications. I wish to rely on the Acupuncturist to exercise judgment that he/she feels at the time is in my best interest, based upon the facts then know during the course of the procedure.

I understand that I have the choice to accept or reject the proposed diagnostic procedure or treatment, or any part of it, before or during the treatment.

I understand that the Acupuncturist is not providing Western (allopathic) medical care, and that I should look to my Western primary care practitioner (i.e. M.D.) for those services and for routine check-ups.

Payment Policy: The payment for the treatment is required to be paid by Cash, Check or Credit Card. Insurance is not accepted, but if necessary, a receipt for the treatment can be issued for the insurance purpose.
Late Cancellation / No Show Policy: a minimum of 24 hours is required to reschedule or cancel an appointment. Unless otherwise agreed upon in advance or in the case of inclement weather, the half price of a treatment will be deducted for each missed appointment. There is a $30 fee for returned checks.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask a question about its content. By signing the 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 for any future conditions for which I seek treatment. Also I give Cozy Acupuncture permission to send information to my contact below.

Patient Signature: _____ Date: ____/____/_____
(or patient representative)

Print Name: _____ Birth Date: ____/____/_____

Address: _____

(City) _____ (State) _____ (Zip) _____

Email: _____ Phone #: _____