Acupuncture Consent to Treatment

I hereby request and consent to the performance of acupuncture treatments and other tradiditional Chinese medicine procedures on me (or on the patient named below, for whom I am legally responsible) by Amy E. Mager, MS, LicAc

I understand that methods or treatments may include but are not limited to acupuncture, rnoxibusti on, cupping, bloodletting, electrical stimulation, Tui Na (Chinese massage), Gua Sha, Chinese or Western herbal medicine, and nutritional counseling.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand the same herbs may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. If I experience any gastro-intestinal reactions to the herbs I will inform the acupuncturist **immediately**.

I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment _____initials
I understand it may be necessary for my practitioner to contact another one **of** my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records for the reasons listed above. _____initials
I authorize the release of all medical information acquired from my examination, situation or treamtment for purposes of claims administration and evaluation, utilization review or financial audit. _____initials

I agree to pay the full charge for any missed or forgotten appointments without 24-hour notice of cancellation ._____initials

I agree to pay all charges incurred for services rendered, over and above insurance coverage. _____initials

To be completed by the patient's representative, if the patient is a minor, or physically/legally incapacitated.

Name of Patient______________________________Patient's Representative______________________________

Relationship or Authority of
Patient______________Witness______________________________
Patient's Name

Patient's Signature______________________________

Date Signed______________________________

Referred by______________________________