Consent to Treatment

I, (print full name)_____, voluntarily consent to be treated with acupuncture. I understand that acupuncture will be performed by inserting sterile, disposable needles through the skin, applying heat, or by some combination of the preceding at specific points on my body. 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 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, and clinic operations. Also, I have given my written consent that my health information be shared with the people, their addresses, and contact numbers below. I understand I can revoke this consent in writing at any time. However, the revocation will not affect any disclosures made in reliance on my prior consent.

Please list the persons with whom we may inform about your health condition(s) and your treatment, including family, physicians, and friends:

_____	_____
Name	Phone
_____	_____
Name	Phone
_____	_____
Name	Phone
_____	_____
Name	Phone

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 the above: "Consent to Treatment", "Release of Information", and "Notice of Privacy Practices and Patient Rights".

_____

Signature

_____ _____

Print Name Date