AESTHETICS & ACUPUNCTURE

800 5th Avenue S
#201 Suite 7
Naples, FL 34102

# ACUPUNCTURE INFORMED CONSENT

_____ the undersigned understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, gua sha, tui na (Chinese massage) and nutritional counseling.

I understand that acupuncture, moxibustion, electrical stimulation, cupping, gua sha and tui na, are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and sores at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting, nerve damage, organ puncture, including lung puncture (pneumothorax), spontaneous miscarriage and possible worsening of symptoms. Infection is possible, although the practice uses alcohol and sterile disposable needles and maintains a safe and clean environment. Clean needle technique is always employed. Potential risks of moxibustion heat therapy are burns, blistering or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha. I fully understand that there is no implied or stated guarantee of success of 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.

I understand that my acupuncturist may review my medical records and lab reports, but all my records will be kept confidential. If it becomes necessary to share my health information, this will be handled in accordance with the stipulations detailed in the Notice of Privacy Policies document that has been provided to me, and of which I have acknowledged the receipt.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment, and healthcare operations received, incurred or carried out at this practice.

By signing below, I show that:

- I have read, or had read to me, the information on this consent form
- I understand the possible risks and complications involved. I have had the opportunity to discuss the consent form with my Acupuncturist. I understand that I can request more information at any time if desired.
- I consent to receive treatment that involves the above procedures.
- I understand that I have the right to refuse of discontinue any treatment at any time. I understand that refusal or discontinuation of treatment should be done in writing and will be kept in my medical file. I understand this refusal may effect the expected results.

X _____
Signature of Patient or Parent/Guardian if minor Date

Witnessed by Staff: _____ Date: _____

**Payment Acknowledgement Form**

I, (print)_____, acknowledge that I am responsible for the "out of pocket" cost for services rendered at DC Aesthetics & Acupuncture. I acknowledge that I have provided my credit card information for payment of services rendered.

(initial) _____ I acknowledge that I am responsible for the payment of my treatment and this practice does not accept insurance.

(initial) _____ If your insurance does have acupuncture benefits, our office can provide a copy of a bill for you to submit on your behalf but will not be involved in the insurance reimbursement process.

(initial) _____ I understand and acknowledge that DC Aesthetics & Acupuncture has a 48 hour cancellation policy and that any appointment not cancelled or rescheduled within 48 hours will be charged the full visit fee.

(initial) _____ I understand that any returned checks will be subject to a $20 processing fee. Failure to replace and pay all returned checks and the processing fee could result in the unpaid balanced being sent to our lawyer for collections.

X _____

Signature of Patient or Parent/Guardian if minor Date