

# Northwest Health & Healing Center

## Acupuncture Consent Form

Acupuncture is performed by the insertion of needles through the skin, and/or by the application of heat to the skin at certain points on or near the surface of the body in an attempt to treat pain, disease, or other dysfunctions.

Adverse side effects may result. These include, but are not limited to, local bruising, minor bleeding, fainting, temporary pain or discomfort, and temporary aggravation of symptoms existing prior to acupuncture treatment.

Acupuncturists may recommend treatment with substances from the Orient. Adverse side effects may result from taking these substances. These include but are not limited to: changes in bowel movements, temporary abdominal pain or discomfort, and the possible problems, which I associate with these substances; I understand that I should stop taking them and call my practitioner.

My practitioner has explained the above treatment, alternatives, and risks to me, and I have had an opportunity to ask questions. I hereby consent to acupuncture treatment.

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Signature of Patient or Legal Guardian

Date

## Payment Policies

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in the collection of funds from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment any fees for professional services rendered will be immediately due and payable. Further, I agree that all funds paid by any third party payer to me for services rendered by my acupuncture provider will be immediately brought to the office for payment on account, should any account balance exist at the time of payment receipt. **I also understand that if I cannot keep my appointment and do not give at least 24 hours notice, billing will be at a regular rate.**

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Signature of Patient or Legal Guardian

Date