Harmony Acupuncture, LLC
Virginia Beach, VA

CONSENT TO SERVICES

I have read and understand both the front and back of this form and acknowledge that the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of the service(s) to be performed have been explained to me. I have also received the Notice of Privacy Practices and the accompanying Practices Regarding Disclosure of Client Health Information. I understand my health information will be used and disclosed consistent with this Notice, and that I have the right to request restrictions on certain uses and disclosures of my health information. Further, I have had the opportunity to ask my practitioner questions regarding the proposed services, this consent form, and other pertinent information, including questions about him or her, and have received satisfactory explanations. I understand that I am free to discontinue service(s) at any time.

To be signed before services are provided.

Is this the first time you have received treatment in Harmony Acupuncture, LLC clinic?

[ ] YES [ ] NO Referred by _____

[ ] Mr. [ ] Mrs. [ ] Ms. _____
Printed Name of Client

_____ _____
Address Date of Birth

_____ _____
City, State, Zip Code Email Address

_____ _____
Home Phone Cellular Phone

_____ _____
Work Phone Name of Practitioner

_____ _____
SIGNATURE OF CLIENT (or parent or guardian if client is a minor) Date

ACUPUNCTURE

Services to be provided

I understand that acupuncture serves individuals with a wide range of complaints including both acute and chronic healthcare issues. I understand that I may be treated with the insertion of needles and/or with the application of heat to the skin.

Risks/Possible Side Effects

I understand that acupuncture may result in certain side effects, including local bruising, slight bleeding, fainting, temporary pain and discomfort, and temporary aggravation of symptoms existing prior to treatment

OTHER ORIENTAL MEDICINE RELATED BODYWORKS

Services to be provided

I understand that all other oriental medicine related bodyworks serves individuals with the same basic concept of Chinese Medicine for a wide range of complaints including both acute and chronic health issues. I understand that I may be treated with Moxibustion, Electric Acupuncture, Cupping, and Guasha. I also further understand that moxibustion involves an application of heat to the skin by burning moxa, electric acupuncture involves an application of low voltage electricity to inserted needles, cupping involves an application of vacuum plastic or glass cups to the skin, and Guasha involves an application of repeated pressured strokes over lubricated skin with a smooth edged instrument.

Risks /Possible Side Effects

I understand that all oriental medicine related bodyworks may result in certain side effects, including slight bleeding, local bruising with temporary skin color change, temporary pain and discomfort.

INFORMATION DISCLOSURES

No Guarantees

I know that each person is unique and has ultimate responsibility for his or her won healthcare. I acknowledge that I have not received any guarantees or promises as to the results or success that will be obtained from the services provided.

Infectious Disease Prevention

I understand that infectious diseases are carried through the air, through physical contact, and through body fluids. I understand that the Harmony Acupuncture, LLC follows universally prescribed precautions and procedures (such as clean needle technique and hand washing) to prevent the spread of infectious disease.

Client Responsibilities

I understand that it is my responsibility as a client to inform my practitioner of all aspects of my health and that, as service progresses, to inform my practitioner of changes that occur. I will inform my practitioner if I am pregnant and/or suspect pregnancy at any time. If I experience any pain, discomfort or possible adverse side effects, it is my responsibility to immediately notify my practitioner.

Medical Treatment

I recognize that a Harmony Acupuncture, LLC practitioner is not a substitute for a medical doctor and will not suggest that I discontinue medical treatment. I understand that if I am currently under a physician's care, I should continue as long as my physician deems necessary. It is my responsibility to consult with my physician before altering any medications or medical treatments. I understand that the Harmony Acupuncture, LLC
Practitioner may request a physical exam if it has been over a year since my last exam. I am free to consult a medical doctor or any other licensed practitioner at any time. I understand also that if there is an emergency, or a worsening of my health condition, or if a new ailment or condition arises, I should consult a licensed physician.

Fees and Charges

I have been informed of the fees for service and I understand that payment is due when the services are provided. If I do not cancel an appointment at lease 24 hours in advance, then I am liable for the fee.