

Informed Consent to Acupuncture and Oriental Medicine Treatment and Care

I, the undersigned, hereby request and consent to acupuncture therapy procedures including, but not limited to needle insertion, electro-acupuncture, moxibustion, cupping, and herbology on me or the patient named below for whom am legally responsible. I authorize Michael Johnson and/or Katie Lundberg to perform those treatments.

Potential Risk: Discomfort, temporary discoloration at site of procedure, occasional aggravation of symptoms existing prior to treatment, occasional mood changes, very occasional fainting or nausea. Potential Benefits: Relief from presenting symptoms, improved balance and well-being, increased positive mood.

I have had the opportunity to discuss with Michael Johnson and/or Katie Lundberg the nature and purpose of the treatments and the procedures used. I understand that there are no guarantees regarding the improvement of my condition. I understand that there are some risks to acupuncture and Oriental medicine, such as those stated above. I understand that those risks may be greater during pregnancy; miscarriages have been reported. If I suspect that I am pregnant, I will immediately inform the acupuncturist.

I hereby release Innerhealth P.C., Michael Johnson and/or Katie Lundberg from all liability, which may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and discontinue participation at any time.

As a courtesy, our office will bill your insurance company. Insurance information provided to our office is not always reliable, and we cannot guarantee its accuracy. We encourage you to call your insurance directly to confirm your coverage and what out of pocket expenses you need to expect. Insurance billing conforms to the requirements of the applicable carrier, and treatment fees depend on the procedure codes. No-shows and same day cancellations are charged at \$ 69 and cannot be billed to your insurance. **If your insurance company declines to pay the bill, you will be responsible for the billed charges.** Your bill is overdue 30 days after services were provided to you. If your bill is turned over to a collection agency, a delinquency charge of \$75 will be added to your balance. I have read and understand the above information. I have received a copy of the "Notice of Privacy Practices."

I have read and understand the above information. I had an opportunity to ask questions before signing. I intent this consent form to cover the entire course of treatment while I am a client at INNERHEALTH P.C. I have received a copy of the "Notice of Privacy Practices."

Signature of Patient

Today's Date

Print Name of Patient

Date of Birth

For Minors:

Print Name of Guardian

Signature

Date

Mailing Address of Guardian