**Fee Schedule:**

Initial exam, diagnosis and treatment: $90

Subsequent Acupuncture Treatments: $75

Herbal Consultation: $40

Herbs: $5-$30

Client or perspective clients committed to their health and the healing process will not be turned away due to financial difficulties. Inquire within to learn about affordable payment options.

**Education and Experience:**

Teresa M. Sullivan, L.Ac., M.S. TCM., Dipl. Ac.Master of Science,Colorado School of Traditional Chinese Medicine in Denver, CO. Graduated with honors on April 22, 2012. This four year program consisted of 2,850 hours of training including 615 hours of clinical acupuncture practice and 180 hours of herbal medicine clinical practice.

**License and Certification:**

Colorado Licensed Acupuncturist #1788

NCCAOM Diplomat in Acupuncture #151527

No licenses have been revoked or suspended

I, Teresa M. Sullivan, comply with all the rules and regulations promulgated by the Colorado Department of Public Health and Environment, including those related to the proper cleaning and sterilization of needles used in the practice of acupuncture and sanitation of acupuncture offices. I use only **one** time use disposable needles.

The Colorado Department of Regulatory Agencies regulates this Acupuncture practice. Any complaints should be directed to the investigation office of the Division of Registrations in the Dept. of Regulatory Agencies at 1560 Broadway, Suite 1350, Denver, CO 80202. Telephone: 303-894-7800.

You as a patient are entitled to receive information about the methods of therapy, the techniques used and the duration of therapy, if known.

In addition to Acupuncture, I also incorporate Moxibustion, Cupping, Tui Na, Dietary therapy, Auriculotherapy, Gua Sha, Electrical Stimulation, Lifestyle counseling, and Chinese Herbal Medicine in my acupuncture practice. I have received training in these techniques from the Colorado School of Traditional Medicine.

You as a patient may seek a second opinion from another health care professional and may terminate therapy at any time.

In this professional relationship, sexual intimacy is never appropriate and should be immediately reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_

**CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION**

**FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS**

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

* A basis for planning my care and treatment.
* A means of communication among the many healthcare professionals who contribute to my care.
* A source of information for applying my diagnosis information to my bill.
* A means by which a third-party payer can verify that services billed were actually provided.
* A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

* To object to the use of my health information for directory purposes.
* To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
* To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

*I request the following restrictions to the use of disclosure of my health information:*

­­­­­­­­­­­­­­­­­­

*I have read and understand this document*

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(Patient Name)

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(Guardian Name)

**HEALTH HISTORY QUESTIONNAIRE**

*All Medical History information is confidential*. **Referred by:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Major Complaint: What is your primary reason for this visit?

1)

2)

3)

What initiates your symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes them better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_What makes them worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your medical doctor’s name and phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact name and phone number in case of emergency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PERSONAL HISTORY

Check any illnesses or conditions you have or have had in the past:

􀀀 AIDS/HIV 􀀀 Bleed Easily 􀀀 Heart Disease 􀀀 Multiple Sclerosis 􀀀 Shingles

􀀀 Alcoholism 􀀀 Cancer 􀀀 Hepatitis 􀀀 Night Sweats 􀀀 Stroke

􀀀 Allergies 􀀀 Chicken Pox 􀀀 High Blood Pressure 􀀀 Pertussis/Whooping Cough 􀀀 Thyroid D/O

􀀀 Anemia 􀀀 Diabetes 􀀀 Jaundice 􀀀 Pneumonia 􀀀 Tuberculosis

􀀀 Antibiotic Use 􀀀 Epilepsy 􀀀 Kidney Disease 􀀀 Polio 􀀀 Ulcers

􀀀 Asthma 􀀀 Glaucoma 􀀀 Mental Disorder 􀀀 Rheumatic Fever 􀀀 Vascular Dis

􀀀 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a PACEMAKER? 􀀀 Yes 􀀀 No

List any surgeries, serious illnesses, broken bones, hospitalizations, etc.:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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♦ List the Date and Results of last medical test:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date** | **Test** | **Result** | **Date**  | **Test** | **Result** |
|  | Cholesterol |  |  | Pap Smear |  |
|  | Hepatitis |  |  | Physical |  |
|  | HIV Test |  |  | PSA (prostate) |  |

Emotions: History of: Mood swings \_\_\_\_\_\_\_\_Anxiety \_\_\_\_\_\_\_\_ Depression \_\_\_\_\_\_\_\_

Irritability \_\_\_\_\_\_\_\_ Abuse \_\_\_\_\_\_\_\_ Attempted suicide \_\_\_\_\_\_\_\_

Circle Current Stress Level: mild moderate high extreme

Typical Food Intake:

Breakfast: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lunch: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dinner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Snacks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treats: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How Much:

Caffeine:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tobacco:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alcohol:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

After eating do you have: (circle) Fatigue Bloating Gas Burping Pain Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: List any drugs, foods, or other substance you are allergic/hypersensitive to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Stools: Constipation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diarrhea:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternating:\_\_\_\_\_\_\_\_\_\_\_\_\_

Sleep: Hours/night:\_\_\_\_\_\_ Time to bed:\_\_\_\_\_\_ Time to wake:\_\_\_\_\_\_ Rested in a.m.:\_\_\_\_\_\_\_\_\_

Trouble falling asleep \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Palpitations:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exercise: Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often:\_\_\_\_\_\_\_\_\_\_\_ Energy Level:\_\_\_\_\_\_\_\_\_

Energy best at what time of day \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Women

Date last menses:\_\_\_\_\_\_\_\_\_ Pregnant? Y N Length of Cycle:\_\_\_\_\_\_\_ #Days Bleeding:\_\_\_

Pain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clots:\_\_\_\_\_\_\_\_ Flow:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Color:\_\_\_\_\_\_\_\_\_\_\_ PMS:\_\_\_\_\_\_\_\_\_\_\_ Irritable:\_\_\_\_\_\_\_\_\_\_\_\_ Mood Swings:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breasts Tender:\_\_\_\_\_\_\_\_ Cravings:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fatigue:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Control:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pregnancies:\_\_\_\_\_\_ Births:\_\_\_\_\_ Miscarriages:\_\_\_\_\_

Menarche Age:\_\_\_\_\_\_\_ Vaginal Discharge:\_\_\_\_\_\_\_\_\_\_\_\_\_ Hx Yeast Infxn’s:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Menopause: Age at Onset:\_\_\_\_\_ Hot Flashes:\_\_\_\_\_\_\_\_\_\_\_\_\_ Night Sweats:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Body System Review

Headache: Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often:\_\_\_\_\_\_\_\_\_\_\_\_ Type of Pain:\_\_\_\_\_\_\_\_\_\_\_\_

Dizziness:\_\_\_\_\_\_\_\_ Numbness/Tingling:\_\_\_\_\_\_\_\_ Eyes: Red:\_\_\_\_\_ Itchy:\_\_\_\_\_ Watery:\_\_\_\_\_

Blurry:\_\_\_\_\_ Floaters:\_\_\_\_\_\_ ↓Night Vision:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Glasses:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ears: Ringing:\_\_\_\_\_\_ Pitch:\_\_\_\_\_\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Throat: Swollen glands/Sore throat:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Neck/Shoulder Tension:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Joint Pain: Knees:\_\_\_\_\_\_\_\_ other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Low Back Pain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Shortness of Breath:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Comments** (anything else you would like to tell us):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking, please include the dosage if you know what it is**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|

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| --- |
| **Medication/Vitamin/Supplement**  |

 |

|  |
| --- |
| **Dosage**  |

 |

|  |
| --- |
| **Symptom**  |

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**Informed Consent (Page 1)**

By signing below and on page 2, I do hereby voluntarily consent to be treated with acupuncture, Oriental medical modalities and/or Chinese herbs by practitioners at Life’s Balance Acupuncture and Herbal Medicine. I understand that acupuncturists practicing in the state of Colorado are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic’s practitioners.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_(Initials)

**Acupuncture/Moxibustion:**

I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or disharmony, to modify or prevent pain perception, and to normalize the body’s physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that there are certain risks associated with acupuncture treatments. These could include, but are not limited to: pneumothorax and spontaneous miscarriage. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time. I understand that if I receive moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_(Initials)

**Chinese Herbs:**

I understand that Chinese Herbs may be recommended to me to treat bodily dysfunction or disharmony, to modify or prevent pain perception, and to normalize the body’s physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment.

*Should I experience any problems, which I associate with these substances, I should suspend taking them and call Life’s Balance Acupuncture and Herbal Medicine as soon as possible. 720-432-9132*

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_(Initials)

**Acupressure/Tui-Na:**

I understand that I may also be given acupressure/tui-na/shiatsu massage as part of my treatment to modify or prevent pain perception and to normalize the body’s physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_(Initials)

*I have read and understand this Informed Consent document and I give my permission and consent to treatment.*

Print\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sign\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(*Patient Name*)

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(*Guardian Name*)

**Informed Consent (Page 2)**

**Cupping/Guasha:**

I understand that I may also be given cupping/guasha as part of my treatment to modify or prevent pain perception and to normalize the body’s physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_(Initials)

**Electro-Acupuncture:**

I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_(Initials)

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I understand that utilizing the services of Life’s Balance Acupuncture and Herbal Medicine, participation in acupuncture, and related treatments is strictly voluntary and that I may discontinue services at any time. I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation.

*I have read and understand this Informed Consent document and I give my permission and consent to treatment.*

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(*Patient Name*)

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(*Guardian Name*)

**Cancellation Policy:**

If unable to keep an appointment, please give us 24 hours notice.

IF YOU FAIL TO KEEP YOUR APPOINTMENT OR CANCEL WITHOUT PRIOR NOTICE, THERE WILL BE A FULL OFFICE FEE.

*I have read and understand the above information and agree to the conditions set forth.*

Print\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sign\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(*Patient Name*)

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(*Guardian Name*)