

**Healthpointe Community Acupuncture  
Informed Consent Form**

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Voluntary Consent**

I hereby voluntarily request and consent to be treated, or give permission for my child/ward to be treated, with acupuncture; electro-acupuncture; acupressure and other techniques based on Traditional Asian Medicine, such as gua sha, cupping or emotional freedom technique; and moxabustion or other warming treatment. I understand I may be given recommendations on diet, lifestyle and nutritional or herbal supplements and it is my decision whether or not to follow these recommendations. The procedures involved in this treatment have been explained to me. I understand I may be treated with the insertion of needles or other non-insertion techniques; electrical stimulation; touch/palpation; with the application of heat; with the application of cupping or gua sha to the skin.

I have not been guaranteed any success concerning the uses and effects of these treatments. I understand that I am free to discontinue treatment at any time.

**Possible Side Effects/Healing Reactions**

I understand that these treatments may result in certain side effects, including local bruising; slight bleeding; fainting; temporary pain or discomfort; mild burning and blistering; and temporary aggravation of symptoms existing prior to treatment. Unusual and rare risks of acupuncture include nerve damage, organ puncture, and infection. I have read the information on this page and understand the possible risk involved.

**Medical Referral**

I understand that I should consult a licensed physician for appropriate medical evaluation and treatment of the conditions for which I am seeking acupuncture treatment. Treatment from this practitioner does not substitute for appropriate medical treatment by a licensed physician. I have been advised that if there is a worsening of my ailment or condition, or if it does not improve within the time estimated by the acupuncturist at the beginning of treatment, or if a new ailment or condition arises, I should again consult a licensed physician. If I am presently under the medical care of a physician, I have been advised to continue all medications and treatments as prescribed until such time as my physician deems it appropriate to reduce or discontinue the medications or treatments. I certify that I have informed Healthpointe of all known physical, mental, and medical conditions and medications, including possible pregnancy, and that I will notify Healthpointe of any changes in my health.

**Infectious Disease/Clean Needle Procedures**

I understand that there is infectious disease carried through the air, through physical contact, and through body fluids. I understand that universally prescribed precautions will be utilized during treatments to guard against the spread of infection, including the use of sterilized, prepackaged disposable needles. Needles that are used for my treatment are used only on me, and are inserted according to clean procedures based on nationally prescribed standards. Needles are disposed of as medical waste immediately after use.

I understand that my questions about the safety of any procedure or treatment or the precautions taken by the practitioner are most welcome and will be answered as fully as possible. I understand I have the right to refuse any treatment or procedure. I have read this form carefully. I have felt free to ask any questions, and it has been satisfactorily explained to me.

**Payment, HIPAA and Cancellation Policies**

Call for the current fee schedule, or check online at [www.healthpointemd.com](http://www.healthpointemd.com). Payment is by check or cash only. Please make checks payable to Healthpointe Enterprises, Inc. Full payment is expected at the time services are rendered. A \$30.00 fee is charged for the first check returned by the bank. If a second check is returned, subsequent payments must be cash.

I have read and agree to Healthpointe's Notice of Privacy Practices, Version 1.2.

If you must cancel your appointment, call as soon as possible to allow time to re-book your time slot. If you miss your appointment without notifying us, or cancel your appointment with less than 24 hours' notice, we charge a \$25.00 late cancellation fee for that appointment. For Monday appointments, you must cancel by 5 p.m. on Friday or it will be considered a late cancellation. Exceptions may be made on a case-by-case basis for medical emergencies or natural disasters.

\_\_\_\_\_  
Signature of Patient or Person Authorized to Consent

\_\_\_\_\_  
Relationship or Authority of Representative

\_\_\_\_\_  
Date