EbbTide Wellness Studio, LLC

ACUPUNCTURE CONSENT FORM

"Acupuncture" means the stimulation of a certain point or points near the surface of the body by the insertion of special needles. 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 and/ or moxibustion.

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

The potential benefits: acupuncture may allow for the relief of one's symptoms without the need for drugs, and improve balance of bodily energies leading to the prevention of illness, or the elimination of the presenting problem.

No Guarantees. I know that each person is unique and has ultimate responsibility for his or her own 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.

lnfectious Disease Prevention. I understand that infectious diseases are carried through the air, through physical contact, and through body fluids. I understand that the practitioner 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. lf I experience any pain, discomfort or possible adverse side effects, it is my responsibility to immediately notify my practitioner.

Medical Treatment. I recognize that my 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. I understand also that if there is an emergency, or a worsening of my health condition, or if a new ailment or condition arises, that 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. lf I do not cancel an appointment at least 24 hours in advance, then I am liable for the fee.

I have read and understand 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 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.

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

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PRINTED NAME OF CLIENT