brad hill
wellness
acupuncture + chinese herbal medicine

Information and Consent to Services

Voluntary Participation
I hereby voluntarily consent to acupuncture treatment. I 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 understand that I am free to discontinue service(s) at any time.

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/Healing Response
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.

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.

Infectious Disease Prevention
I understand that infectious diseases are carried through the air, through physical contact, and through body fluids. I understand that my 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 about all aspects of my health and that, as treatment progresses, to inform my practitioner of changes that occur. 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 an acupuncture practitioner is not a substitute for a medical doctor and will not suggest that I discontinue medical treatment. 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, that I should consult a licensed physician.

Confidentiality and Exceptions
I acknowledge that I received a copy of my practitioner's Notice of Privacy Practices and the accompanying Practices Regarding Disclosure of Client Health Information, which describe my practitioner's policy of respecting clients' right to privacy and the exceptions that require disclosure of confidential information.

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 least 24 hours in advance, I will be responsible for the full fee.

I have read and understand both the front and back of this form. 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 felt free to ask my practitioner questions regarding the proposed services and other pertinent information, including questions about him or her, and have received satisfactory explanations.

Print name of client	Date
Signed by client	Date
Signed by parent or guardian if client is a minor	Date

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