

Four Seasons Acupuncture, Inc.

Voluntary Informed Consent to Treat

I voluntarily consent to participate in therapy performed by or under the supervision of Marlo Rapp, A.P., DOM.

I understand that the scope of treatment may include acupuncture, electric-stimulation acupuncture, auricular acupuncture, acupressure, acupoint injection therapy, muscle stimulation, cupping, moxa, tuina, gua-sha, herbal /western formulas, and homeopathic remedies. I understand that I may refuse any of these treatments.

I understand that acupuncture or certain herbal and homeopathic remedies may be contraindicated during the following conditions: pregnancy, a prevailing condition of stress, fatigue, or a weakened immunity/state.

I understand that under certain conditions nausea, dizziness, or fainting may occur. I also understand that bruising, hematomas, bleeding, temporary soreness, or the possible aggravation of symptoms prior to treatment and following treatment may occur.

No guarantees or assurances have been made concerning the results of this treatment or procedure. I have not withheld any information regarding my medical history and unless otherwise stated, I assert that I am in good health and I am fully aware of what I am signing.

All professional fees are due in full at the time services rendered. I hereby acknowledge and accept full responsibility for any and all costs incurred. It is the patient's responsibility to request reimbursement from their health insurance plan if the patient desires reimbursement of costs paid.

Patient Signature: _____ Date: _____

Cancellation Policy

I agree to cancel or reschedule appointments with a minimum of 24 hours' notice. I understand that each incident will result in a \$35 fee.

Patient Signature: _____ Date: _____

For Official Use Only:

Credit Card (circle one): Visa MasterCard Discover

Name on Card: _____ Card #: _____

Expiration Date: _____ Signature Code: _____
