A Greater Well Being

5613 Goucher Dr.
College Park MD, 20740
301-345-7385

Voluntary Consent

I hereby voluntarily request and consent to be treated or give permission for my child/ward to be treated, with acupuncture, moxabustion, herbs, Asian Bodywork or other supplemental recommendations, administered by a licensed acupuncturist at A Greater Well Being. The procedures involved in these treatments have been fully explained to me. I understand that I may be treated with the insertion of needles, touch/palpation, and/or the application of heat 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 acupuncture and moxabustion 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. Conventional medical therapy may also be indicated, either in response to an emergency or as deemed necessary at the discretion of a licensed physician.

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.

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 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.

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.

Fees

I understand and agree that I am responsible for payment of all fees associated with treatment. If I am using health insurance or another third-party payment option, I understand that I am responsible for all fees not covered.

Cancellations

I understand that my appointment is reserved for me and I agree to pay the full fee for the missed session if I cancel an appointment with less than 24 hours notice (other than for serious illness or accident).

I have read this form carefully and understand the entire contents. I have felt free to ask any questions.

_____ _____

Printed Name of Client Signature of Licensed Acupuncturist

_____ _____

Signature of Client or Guardian Date

_____
Printed Name of Guardian