WATKINS
ACUPUNCTURE
CLINIC

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Information and Consent to Services

Voluntary Participation:
I hereby voluntarily consent to treatment provided by Watkins Acupuncture Clinic. I acknowledge that the purposes, goals, techniques, procedures, limitations, potential risks and benefits of the service to be performed have been explained to me. I understand that I am free to discontinue services at any time.

Services To Be Provided:
Treatment may include Acupuncture and Zero Balancing. I understand that I may be treated with the insertion of needles and/or with the application of heat to the skin.

Risk/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.

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 disease.

Client Responsibilities:
I understand that it is my responsibility to inform my practitioner of all aspects of my health on the intake questionnaire, including any changes in my health status since my last service date. If there is a worsening of an ailment or condition, or if a new ailment or condition arises, I should consult a licensed physician. I also understand that if I am currently under a physician's care, I should continue as long as my physician and I deem it necessary. I further understand that my practitioner does not recommend altering medications or other therapies without first consulting my personal physician or health care provider and that the services at Watkins Acupuncture Clinic are not intended for the diagnosis or treatment of disease.

Privacy: I have received the Notice of Privacy Practices.

Fees and Charges:
I have been informed of the fees for service, and I understand that payment is due at the time when services are provided. If I do not cancel an appointment at least 24 hours in advance, then I am responsible for a $50.00 "no show" or "failure to give sufficient notice fee". X_____ (initial here).

By voluntarily signing below, I confirm that I have read, or have had read to me, and understand the above Consent to Watkins Acupuncture Clinic Services, have been told about and understand the risks of each of the Watkins Acupuncture Clinic Services, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

X_____
Printed name of client

X_____
Signature of client or guardian

X_____
Date