Monica Shields, Lic.Ac., M.Ac.
Licensed Acupuncturist

Consent to Treatment

I, the undersigned (or the legal guardian of the patient to be treated), consent to acupuncture treatments and other East Asian medical treatments performed by the licensed acupuncturist listed below.

I understand that the East Asian medical treatments I am consenting to may include, but are not limited to, acupuncture, moxabustion, cupping, gua sha, bloodletting, magnetic therapy, heat lamp therapy, electrical stimulation, and Tui Na (Chinese massage).

I understand that I have the right to refuse any form of treatment. I have been given the opportunity to ask questions about this consent form and have read or have had this consent form read to me. By signing below, I understand that I am agreeing to the aforementioned procedures. I understand that there is always the possibility of an unexpected complication during the course of my treatments. I also understand that Monica Shields, Lic.Ac. does not guarantee that my condition will be cured over the course of my treatments. I intend this consent form to be valid throughout my entire course of treatment with the acupuncturist listed below, regardless of whether my health condition changes. _____
Initials

I hereby give my consent to the acupuncturist named below to contact another one of my health care practitioners in order to share appropriate medical information. My signature on this consent form gives my health care practitioner permission to release my records to the acupuncturist listed below for the reason mentioned above.

_____
Initials

I understand my acupuncturist's office policies and consent to pay the full charge for any missed or forgotten appointments without 24-hour notice of cancellation. _____
Initials

I understand that I am financially responsible for the charges I incur during my treatments and I agree to pay for all services rendered. _____
Initials

_____
Patient's Name

_____
Patient's Signature

_____
Date Signed

_____
Acupuncturist

To be completed by the patient's legal guardian, if the patient is a minor, or physically/legally incapacitated.

_____
Name of Patient

_____
Name of Patient's Representative

_____
Relationship or Authority of Patient

_____
Witness