Name________________________________________________________ Date__________________

Address________________________________________________________________________________

City/State/Zip__________________________________________________________________________

Cell Phone_____________________________________________________________________________

Email ________________________________________________________________________________

Birthday (mm/dd/yyyy) _________________

Have you had acupuncture before? ________________________________________________________

Occupation ____________________________________________________________________________

Emergency contact name/phone ___________________________________________________________

How did you hear about us? ______________________________________________________________

Please tell us what we can help you with:

_____________________________________________________________________________________

_____________________________________________________________________________________

Please list any hospitalizations or serious medical conditions that have required a doctor's care in the last 5 years:

_____________________________________________________________________________________

_____________________________________________________________________________________

Please mark all that apply:

__ epilepsy/seizures
__ Hepatitis B or C
__ HIV/AIDS
__ bleeding disorder or hemorrhage
__ fainting
__ taking blood thinners

Is there anything else you would like us to know about you? _________________________________________

_____________________________________________________________________________________

## Informed Consent for Acupuncture Treatment

I understand that:

- If I need to be woken up at a certain time, I will let the acupuncturist know.
- I might be too relaxed to drive immediately after treatment.
- If other people's snoring bothers me, I will use earplugs or headphones.
- Community acupuncture involves actual community with a wide variety of people, and may require some flexibility, patience, and understanding.

I, the undersigned, hereby request and consent to treatment by acupuncture and/or other procedures within the scope of the practice of Oriental Medicine. I am hereby informed that the treatment methods are all generally safe but that there may be some side effects or risks.

**Potential Side Effects:**
At the site of needle insertion there may be **soreness, numbness, tingling, bruising, swelling, or temporary nerve damage**. A person might also experience rare side effects such as weakness, fainting, spontaneous miscarriage, organ puncture, and infection - although Acupuncture Together uses only sterile, disposable needles and maintains a clean and safe environment. Acupuncture can cause aggravation of symptoms existing prior to acupuncture treatment and appearance of new symptoms.

The herbal and nutritional supplements recommended to me by my practitioner are generally safe in the traditionally recommended doses. Possible side effects of herbs include nausea, gas, stomach ache, diarrhea, and headache. Unusual side effects of herbs include vomiting, rashes, hives, and tingling of the tongue. I understand I must stop taking any herbs and notify my acupuncturist if I experience any discomfort or adverse reaction.

I understand that I have the right to refuse any part of the treatment. I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose, although I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known. 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 with Acupuncture Together.

*I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant as certain acupuncture points and herbs are contraindicated during pregnancy.*

____________________________________ ____________________
Patient Signature Date

____________________________________ ____________________
Guardian Signature (If patient is under 18) Date

**Form to be completed by Patient, Notifying the Acupuncturist of Whether He/She Has Been Evaluated by a Physician, and Other Information.**

(Pursuant to the requirements of 22 TAC §183.7 of the Texas State Board of Acupuncture Examiners' rules (relating to Scope of Practice and Tex. Occ. Code Ann., §205.351, governing the practice of acupuncture.)

I (patient's name) ________________________________________, am notifying the acupuncturists at Acupuncture Together of the following:

- I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed.

  ___ Yes ___ No

  _____ (initials of patient) Date: ____________

- Or, I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

  ___ Yes ___ No

  _____ (initials of patient) Date: ____________

- I have received a referral from my chiropractor within the last 30 days for acupuncture.

  ___ Yes ___ No

After being referred by a chiropractor, if after two months or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

- I have not been evaluated by a physician or dentist for the condition being treated, nor have I received a referral from a chiropractor, but I seek treatment for symptoms related to one or more of the following conditions:

  ___ Chronic Pain ___ Alcoholism

  ___ Smoking addiction ___ Substance abuse

Should I return for treatment for any condition other than my original condition(s) treated at this clinic, I understand it is my responsibility to be evaluated by a physician prior to acupuncture.

______________________________________________ ____________________
Patient Signature Date

______________________________________________ ____________________
Guardian Signature (If patient is under 18) Date

## Cancellation Policy

If you have scheduled an appointment with us, we are saving a chair just for you. With respect to our intention to provide high quality acupuncture with affordable prices we ask for 24 hours of advanced notice if you must cancel or reschedule an appointment. This gives us time to fill the vacant space in our schedule and helps us keep rates affordable. You may cancel or reschedule by phone or by using our online appointment scheduler. You may also leave us a voicemail or text outside of regular business hours.

Please note, you will be charged:

$25 late cancellation fee for appointments cancelled or rescheduled within less than 24 hours.

$33 no call/no show fee (full treatment price) for “No Show” appointments.

Thank you for cooperation & understanding,

Acupuncture Together Staff

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I affirm that I have read the cancellation policy and that I am aware of the **$25 late cancellation or reschedule fee** within less than 24 hour notice and the **$33 no call/no show fee.**

Patient name (print) ______________________________________________________

Patient Signature ______________________________________________________

Date: ________________