Information and Consent to Treatment

The Integrative Medicine Center
Janet Smith Acupuncture LLC
366 Mill Street Hagerstown Md 21740
240/420-8625

Consent to Services: I hereby voluntarily consent to acupuncture treatment. I acknowledge that the purposes, goals, techniques, procedures, limitations, potential risks and benefits of the services to be performed have been explained to me. I understand that I am free to discontinue services at any time.

Acupuncture Services to Be Provided: I understand that acupuncture serves individuals with a wide range of complaints including both acute and chronic healthcare issues. I understand that I may be treated with the insertion of needles and/or with the application of heat to the skin.

Risks, Possible Side Effect and Healing Response: 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. Conventional medical therapy also may be indicated, either in response to an emergency or as deemed necessary at the discretion of a licensed physician.

Information Disclosures: I know that each person is unique and has ultimate responsibility for his or her own healthcare. I acknowledge that I have not received any guarantees or promises as to the results or success that will be obtained from the services provided.

Infections Disease Prevention: I understand that infectious diseases are carried through the air, through physical contact, and through body fluids. I understand that the acupuncturist follows universally prescribed precautions and procedures, (such as clean needle technique and hand washing), to prevent the spread of infectious disease.

Client Responsibilities: I understand that it is my responsibility as a client to inform the acupuncturist about all aspects of my health and that, as service progresses, to inform my practitioner of changes that occur. If I experience any pain, discomfort, or possible adverse side effects, it is my responsibility to immediately notify my practitioner.

Medical Treatment and Referral: I recognize that the acupuncturist is not a substitute for a medical doctor and that she will not suggest that I discontinue medical treatment. I am free to consult a medical doctor or any other licensed practitioner at any time. I understand also that if there is an emergency, or a worsening of my health condition, or if a new ailment or condition arises, that I should consult a licensed physician.

Confidentiality: I understand that confidentiality and anonymity will be preserved at all times.

Fees and Cancellation Policy: I have been informed of the fees for service and I understand that payment is due when the services are provided if at all possible. I understand that I am requested to cancel an appointment at least 24 hours in advance or a late cancellation fee may be charged. Janet Smith Acupuncture LLC and The Integrative Medicine Center may use and disclose protected health information in order to bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, I may give your health plan information so that they will pay for your treatment.

I have read this form and the **Notice of Privacy Practices Form** carefully and understand these forms. Further, I have felt free to ask my practitioner questions regarding the proposed services and other pertinent information, including questions about him or her and received satisfactory explanations.

Patient Name (print) ____

Patient Signature ____ Date _______________

Parent or Guardian signature____ Date _______________
(if Patient is a minor)