**Informed Consent to Acupuncture Treatment**

I hereby request and consent to the performance of acupuncture treatment by the chiropractic acupuncturist.

I further understand that such acupuncture services may be performed by the Physician at **Restoration Health & Chiropractic**. I have had an opportunity to discuss with **Dr. Colleen Fazio** and/or with other office or clinic personnel the nature and purpose of acupuncture and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of acupuncture carries some risks to treatment; including, but not limited to: bruises, light-headedness,, dizziness, needle sickness, and nausea. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient: To be completed by the patient’s representative, if necessary, (e.g. if the patient is a minor or is

physically or mentally incapacitated)

Print Patient’s Name Print Name of Representative

Signature of Patient Signature of Representative

Date: / /

 Date: / /\_\_\_\_\_\_\_\_\_\_\_\_\_

**Office Policies**

I hereby have read and agree to the following office policies:

-There is a strict 24-hour cancellation notice. All cancellations requests are subject to approval by the doctor. If I fail to cancel or reschedule my appointment within the allotted time I will either: **forfeit my session (if already paid for) or will be charge a missed cancellation fee of no less than $50.**

-As a courtesy, the office will bill the patient’s insurance for their visits. It is the **RESPONSIBILITY** of the patient to know their benefits as well as their visit limits. The office will not be responsible if visit limits are exceeded, so it is important to be acquainted with your own benefits. We will, however, verify your benefits for you as well as discuss them with you.

-If you do not have insurance, payment is expected at the time of service. Copays will also be collected at the time of service.

I have read, or have had read to me, the above consent.

To be completed by the patient: To be completed by the patient’s representative, if necessary, (e.g. if the patient is a minor or is

physically or mentally incapacitated)

Print Patient’s Name Print Name of Representative

Signature of Patient Signature of Representative

Date: / /

 Date: / /