Claudia Olson, L.Ac., M.Ac.
Acupuncture

Consent to Services

Services to be Provided

I understand that acupuncture serves individuals with a wide range of complaints including both acute and chronic health care issues. I understand that I may be treated with needles and/or the application of heat to the skin.

Risks/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.

No Guarantees

I know that each person is unique and has ultimate responsibility for his or her own health care.
I acknowledge that I have not been given any guarantees or promises as to the results or success concerning the uses and effects of acupuncture.

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 infectious disease.

Client Responsibilities

I understand that it is my responsibility as a client to inform my practitioner of all aspects of my health and to inform my practitioner of changes that occur. I will inform my practitioner if I am pregnant and/or suspect pregnancy at any time. If I experience pain, discomfort or possible adverse side effects, it is my responsibility to immediately notify my practitioner.

Payment Policy

I understand that the cost of the session is payable by cash, check, or credit card. If I need to cancel an appointment, I must call at least 24 hours in advance, and I understand that non-emergency cancellations (less than 24 hours) are subject to a late cancellation fee.

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patient signature date

____ _________________________

patient name (printed) phone number

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witness name (printed) witness signature date