

CONSENT FOR TREATMENT AND PAYMENT

I _____ hereby consent to receiving Acupuncture/
Traditional Chinese Medicine (TCM) treatments and therapies as agreed upon by myself and my
TCM therapist.

I understand that Acupuncture/TCM treatments are not the same as conventional medical
treatments. I understand that all treatment protocols are individualized and based on TCM
principles and philosophies, which I have had an opportunity to discuss with my TCM therapist.
I further understand that no treatment offers a guarantee of cure.

I understand that there is a cancellation policy and that 24 hours notice is required to reschedule
or cancel my appointment, or I will be charged the full fee. I understand that this policy is
implemented in order to accommodate other patients waiting for an appointment. I further
understand that all payments are due in full after each visit.

I understand that the information given on this form is confidential and will be released to other
health care professionals only with my written consent.

I have read and understand the above consent and have had an opportunity to ask questions about
its content. I am also aware that this consent is applicable during the entire course of treatment.

Patient Name (*Please Print*)

Patient Signature

Date