INFORMED CONSENT
Lisa B. Anderson, MSOM, Dipl.OM, LAc
Courtney Smith, MSAc., Dipl. Ac, LAc

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the client named below, for whom I am legally responsible) by the acupuncturist named above. The procedures involved in this treatment have been explained to me. I understand the treatment methods may include acupuncture, gua sha, shonishin, moxibustion, cupping, herbal medicine and nutritional counseling.

I understand that acupuncture is a generally safe method of treatment, and may result in certain side effects, including local bruising, slight bleeding, fainting, temporary pain or discomfort and/or 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 in the discretion of a licensed physician.

The practitioner uses only sterilized, pre-packaged disposable needles. Needles that are used for my treatment are used only on me, and are inserted according to clean needle procedures based on nationally prescribed standards.

I have not been guaranteed any success concerning the uses and effects of acupuncture. I understand that I am free to discontinue treatment at any time.

Confidentiality and anonymity of every client will be preserved at all times. All my records will be kept confidential and will not be released without my written consent.

I understand that if I miss an appointment without 24 hour notification I will be charged a $95.00 fee.

I have read this form carefully and understand I am free to ask any questions I may have regarding treatments.

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Print name- Client	Signature	Date

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Print name- Acupuncturist	Signature	Date