KELLY HERB ACUPUNCTURE **(805) 302-0266**

Acupuncture - Informed Consent

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 patient named below, for whom I am legally responsible) by Dr. Kelly Her., L.Ac. I understand that there are some minor risks to acupuncture treatment, including, but not limited to some slight bruising of the skin (hematoma) and/or slight bleeding. I understand that the risk of infection is negligible when all needles are sterile. I have had an opportunity to discuss with the Acupuncturist named herein and/or with other office or clinical personnel the nature and purpose of acupuncture. I understand that results are not guaranteed. I do not expect the Acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the Acupuncturist to exercise judgment during the course of the procedure which the Acupuncturist feels at the time, based upon the facts then known, is in my best interests. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

About Your Treatment

1. We use only sterile, single-use disposable needles.
2. Sometimes, after receiving an acupuncture treatment, you may feel a little bit light headed. If that happens, please sit for a while in the waiting room. In a few minutes you'll feel fine.
3. Herbal prescriptions and herbal patent medicines are intended only for the person for whom they are dispensed. Because of the individualized nature of herbal prescriptions, we cannot restock them.

HIPPA – Notice of Privacy Practices

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide ***Kelly Her L.A.c*** with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____ _____X_____

Date Printed Name Patient Signature (or guardian, if minor)

Consent to Treat a Minor

I (we) being the parent or guardian of _____a minor, the age of _____do hereby consent, authorize, and request Kelly Her, L.A.c, to administer such treatment deemed advisable, necessary or requested on the above minor.

_____ _____X_____

Date **Printed Name** **Patient Signature (or guardian, if minor)**

I certify that the above information is complete and accurate to the best of my knowledge. I understand that I am liable for all charges for services rendered and I agree to notify the doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

I understand there will be a $15 charge to my account for missed appointment without a 24 hours notice. Payment is expected when services are rendered unless other arrangements are made in advance.

Patient Signature_____Date_____