

Abundant Spring • Fertility Acupuncture and Chinese Herbal Medicine Treatment Authorization and Privacy Policy

I, the undersigned, authorize **Lee Hullender, LAc or Roxane Geller, LAc, LMP, (independent contractor)** to perform the following procedures:

Acupuncture: The insertion of sterile, disposable needles through the skin into underlying tissues at specific points on the body.

Cupping: The application of glass cups to the skin in a manner as to create suction.

Moxibustion: The burning of an herb on or near an acupuncture point.

Acupressure: The application of pressure to the acupoints.

Tuina: A vigorous type of massage.

Gua Sha: The rubbing on an area of the body with a blunt instrument.

Plum Blossom / Seven Star Hammer: Light tapping over a body surface with a small hammer that has seven small, sterile needles.

Bleeding Technique: The piercing of an acupoint with a sterile lancet in order to release a few drops of blood.

TDP Lamp: A mineral heat lamp used to warm a large area of the body.

I recognize the potential risks and benefits of these procedures as described below:

Potential Risks: Pain, bruising, bleeding, infection, and/or blistering at the site of the procedure; temporary discoloration of skin and possible aggravation of symptoms existing prior to the acupuncture treatment.

Potential Benefits: Drugless relief of presenting symptoms and energetic balancing that may lead to prevention, improvement or elimination of presenting problem.

initials of patient _____

CANCELLATION POLICY:

Please give me at least 48 hours notice if you need to cancel or change your appointment. It is my policy to charge you the FULL AMOUNT for any missed visits or same day cancellations.

initials of patient _____

PRIVACY POLICY:

All information you give to me is kept strictly confidential with the following exception: A mailing list is compiled by my staff that is used only by me to inform you of changes in the practice and billing (i.e. address changes, etc.) No information will be released without your express written consent.

initials of patient _____

With this knowledge I voluntarily consent to the above procedures, realizing that no guarantees have been made to me by my practitioner regarding cure or improvement of my condition. I release my practitioner from any and all liabilities which may occur in connection with the above mentioned procedures except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw this consent and to discontinue participation in these procedures at any time.

Signature of patient or legal guardian

Date