

CANCELLATION POLICY:
**ALL APPOINTMENTS CANCELED UNDER 48 HOURS WILL
BE CHARGED A FLAT \$40 FEE AND MUST BE PAID PRIOR
TO YOUR NEXT SESSION.**

*Please don't be that person that cancels right after we
send you a text reminder for your appointment 😊*

CONSENT TO TREATMENT

I, _____, voluntarily consent to receive Acupuncture and/or Chinese Herbal Medicine treatment administered by Madison Community Acupuncture, whose acupuncturists are certified by the State of Wisconsin Department of Regulation and the NCCAOM. I understand that although they are trained in basic Western Medical Theory as part of their four-year Master's Degree, their training is predominately in Acupuncture and Oriental Medicine and that they are not, nor claim to be, medical doctors.

I understand that any evaluation or examination given me is an energetic assessment of the functioning of the organ system, the energy moving in the acupuncture meridian network, and the blood moving throughout the circulatory system. It in no way purports to be, or replaces allopathic (western) medical evaluation, diagnosis, or treatment.

I have provided a full history and description of complaints which is complete and accurate. I understand that the need for communication with all of my health care providers regarding my health status is ongoing and necessary. I understand that no guarantee has been made concerning the use and effects of Acupuncture and Chinese Herbal Medicine.

I understand that Acupuncture is the insertion of fine sterile needles through the skin to regulate and balance blood and energy flow, improve organ function and improve health.

I acknowledge that there are three potential responses to care: an improvement of symptoms, healing reactions (an indication of improvement), and/or side effects (undesirable experiences). Although rare, minor side effects may result from Acupuncture. These may include minor bruising, minor bleeding, and some pain at the site of needle insertion.

I am choosing Acupuncture and/or Chinese Herbal Medicine treatment as an exercise of my right to freedom of choice in the healing arts.

Signature of Patient

Date