



## PATIENT INFORMATION AND CONSENT FORM

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Sex: \_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Policy No. \_\_\_\_\_  
Insurance Subscriber (if other than yourself): \_\_\_\_\_  
Subscriber's Employer: \_\_\_\_\_  
Subscriber Birthdate: \_\_\_/\_\_\_/\_\_\_ Relationship to you: \_\_\_\_\_

I understand that acupuncture is an energetic form of therapy that may affect people on all levels: physical, emotional, mental and spiritual, because it works within the entire body to restore balance. I understand that the duration of treatment varies depending on the specific illness and body constitution. I understand that there is no guarantee being made for the outcome of such treatment.

I further understand that I shall be referred to a medical doctor where indicated and I assume full responsibility for consulting with the appropriate physician if this is necessary.

I state that I have completed the patient information form completely and accurately, and understand and give consent to Peaceful Spirit Acupuncture Clinic and its representative to treat my complaints and symptoms using the diagnostic and therapeutic methods according to Traditional Chinese Medicine. I have been informed as to the risks and benefits of acupuncture, TDP lamp, moxibustion and herbal treatments. 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.

I will inform the acupuncturist of any of the following:

- Possibility of pregnancy
- Any medications
- Any diagnosis or exposure to Hepatitis or HIV

I understand that all records will be kept confidential and will not be released without my written consent.

**I further understand that it is the policy of Peaceful Spirit Acupuncture Clinic to charge a \$35 fee for returned checks, for missed appointments or for cancellations made with less than a 24-hour notice, regardless of insurance coverage.**

\_\_\_\_\_  
Patient Signature (Parent or Guardian if under 18)

\_\_\_\_\_  
Date