CLIENT CONSENT AND RELEASE OF LIABILITY

I _____, hereby request and consent to recurring
(Please Print First and Last Name)
acupuncture treatments and other related procedures. I understand that acupuncture services are designed to be a health aide and are in no way a substitute for a doctor's care. I understand that the modalities of treatments may include, but are not limited to, acupuncture, massage, Aroma Acupoint Therapy™, cupping, electrical stimulation, Tui-Na (Oriental Massage), Oriental herbal medicine, and/or nutritional and lifestyle counseling.

I have been informed that acupuncture is a generally safe method of treatment, but may result in some minor side effects, including mild bruising, sensitivity or tingling near the needling sites that may last a few days, and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage or organ puncture, including lung puncture (pneumothorax). Although the clinic uses only sterile disposable, one-time use needles and maintains a clean and safe environment at all times, there may be possible risk of infection. Burns and/or minor scarring are a potential risk of cupping. I understand that massage therapy is for the purpose of general health maintenance, stress reduction, relief from muscular tension, adjunct to optimal athletic performance, general relaxation, and improvement of circulation. Treatments may include muscular tension release, myofascial release, trigger point therapy, joint mobilization, stretching, and manual therapy. Aroma Acupoint Therapy™ is a form of medical aromatherapy that uses pure essential oils. I am aware that there is a slight chance some of the oils can be irritating to the skin. I will inform my practitioner if I have any allergies, aversions, or if I develop sensitivity to essential oils during the course of treatment. I have been informed of the potential and/or temporary side effects of any or all modalities performed to me in this clinic.

Information exchanged during sessions is educational in nature and is to be used at my own discretion. I will notify my practitioner of any health or dietary situations that are present or will arise during the course of my treatments at this clinic, including pregnancy. I agree to communicate with my practitioner if, at any time, I feel that my well-being and/or comfort is being compromised. I will communicate with my practitioner if I experience pain or discomfort during my treatment.

I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on them to exercise judgment during the course of treatment which they think appropriate at the time, based upon the facts then known is in my best interest. I understand that the results of treatment are not guaranteed.

My treatment sessions are documented. All of my records will be kept strictly confidential and will not be released without my written consent.

Payment shall be expected in full at time of service. I understand and agree that health and accident insurance policies, including worker's compensation, are an arrangement between the insurance carrier and myself. Furthermore, I understand that this office will provide a Superbill to be submitted by me to the insurance company for any reimbursements in the event that my policy shall cover treatments. I understand that my insurance policy may or may not cover some or all of the services I receive and may have coverage limitations and restrictions. I understand that it is my responsibility to understand what my insurance plan covers.

By voluntarily signing below, I show that I have read or have read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, agree to the payment policies of this office, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment. I hereby release, discharge, and hold harmless Mayan Moon Healing, LLC, its owner and assigns from any and all liability for any claims, demands, actions, judgments and damages arising from utilization and participation in acupuncture and related services.

Client's or Legally Authorized
Person's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

CANCELLANTION POLICY ACKNOWLEDGEMENT

In our desire to be effective and fair to all clients, the following policies are honored:

- **Cancel:** Kindly give at least **24 hours** notice for cancellation or rescheduling. This allows the opportunity for someone else to schedule an appointment. If you are unable to give us 24 hours advance notice, you will be charged the **full amount** of your appointment. This amount must be paid prior to your next scheduled appointment.

- **No-show**: If you forget or consciously choose to forgo your appointment for whatever reason, you will be considered a "no-show." You will be charged for your missed appointment. This amount must be paid prior to your next scheduled appointment.

- **Late Arrivals**: If you arrive late for your scheduled appointment, your session may be shortened in order to accommodate others whose appointments follow yours. If you arrive more than 15 minutes late, your practitioner will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, you will be responsible for the **full** session.

- **Scheduling**: It is recommended you schedule your appointments at least one week in advance to ensure the times that you need. Appointments given one week do not automatically follow through to the subsequent weeks.

_____ Client and practitioner have discussed the importance of frequency and duration of treatment.

Initials

Thank you for your cooperation, consideration, courtesy, and promptness!

Client's or Legally Authorized
Person's Signature:_____ Date: _____

Practitioner Signature: _____ Date: _____