Gentle Healing ACUPUNCTURE

221 South First St., Ste. A, Eagle River WI 54521
715-477-2431

Consent to Treatment Form

By signing below, I request and authorize the treatment of acupuncture and/or herbs or supplements and/or additional modalities such as bodywork, cupping, gua sha or photobiomodulation therapy as may be deemed necessary and appropriate by a licensed acupuncturist at Gentle Healing Acupuncture, LLC. I understand that acupuncturists in the state of Wisconsin are not primary care providers and that regular primary care by a licensed physician is a personal choice and is strongly recommended by this clinic's practitioner.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result which may include, but are not limited to: bruising, bleeding, fainting, discomfort, pneumothorax and skin burns as well as possible aggravation of the symptoms existing prior to the treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Chinese Herbs/ Medicinal Substances: I understand that substances from the Oriental Materia Medica, supplements or essential oils may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do choose to take them. I am aware that certain adverse side effects may result from taking these substances which could include, but are not limited to: abdominal pain or discomfort, changes in bowel movement, and the possible aggravation of symptoms existing prior to herbal treatment.

Acupressure/ Bodywork/ Cupping: I understand that I may also be given acupressure/ Bodywork/ Cupping which may include the topical use of massage creams or essential oils as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that electro-acupuncture may be recommended in addition to acupuncture. If I agree to this treatment, I understand that certain adverse side effects may result which may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment. I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

Low Level LED Light Therapy/ Photobiomodulation therapy: I understand that light/photobiomodulation therapy may be used to obtain therapeutic benefits for pain, inflammatory or skin conditions. I understand that although this therapy FDA-cleared to treat various conditions and is considered safe for most people, certain adverse reactions may result which include, but are not limited to redness, rash, increased pain, increased inflammation or a worsening of the condition being treated. I understand that no guarantees concerning its use and effects are given to me and I may refuse this type of treatment.

I have carefully read and understand all of the information found on page 1 of this consent form and I am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I voluntarily give my permission and consent to treatment.

Patient Signature:_____ **Date:**_____

Date of Birth:_____ **Phone:**_____

Office Policies

Billing: Payment, with check or cash in full, is required at the time of the visit unless other arrangements have been made.

Initial _____

Insurance Coverage: Many insurance policies cover acupuncture, but we do not claim that yours does or that we are in network with your insurance carrier. We can verify your coverage if you provide us with your insurance card and a photo ID. If we are a contracted provider with your insurance company and your policy currently covers acupuncture treatment, we will submit your claim form for reimbursement, provided you sign the financial agreement below.

Initial _____

Release of Information: Your insurance company may require your personal information and/or medical reports to document our treatment and progress. Your initials below authorize the release of medical information necessary to process your claim.

Initial _____

Appointments: As a courtesy to our office and other patients, please notify us at least 24 hours in advance if you need to cancel or reschedule your appointment. You may be charged the full cost of your treatment for any missed appointment or cancellation with less than 24 hours notice in any non-emergent situations.

Initial_____

Financial Agreement/ Assignment of Benefits

I, (print full name)_____, am receiving or I will be receiving health care services at Gentle Healing Acupuncture LLC. I understand that I am responsible to pay all non-insurance related fees when services are rendered, including herbs, etc. If I choose to use my insurance, I understand I will be responsible for all "non covered" services and/ coinsurance/ co-pays associated with my office visit. In addition, I authorize insurance payment of medical benefits to Kristine Cloutier, L.Ac. of Gentle Healing Acupuncture LLC.

By signing below, I acknowledge that I have read, understand and agree to comply with the office policies stated above. I also authorize the use of this signature on all insurance submissions.

Patient Signature:_____ **Date:**_____