NOTICE OF PRIVACY PRACTICES
OFFICAL HIPAA NOTICE

Dear Client,

At Dr. Xie's Acupuncture Clinic, we are committed to protecting your privacy and the confidentiality of your records. To this end, we have designed a comprehensive program in our office. All personnel have been sufficiently trained and sensitized to not only the state and federal requirements, but to the ethical handling of your personal information.

This information was prepared to comply with the federal regulations that enforce the Health Insurance Portability and Accountability Act of 1996, which is known as HIPAA. These new regulations effective April 14th, 2003 set forth certain legal requirements regarding how hospital and healthcare providers must protect your medical records. This information explains the details and your rights under the law and activities associated with Dr. Xie's Acupuncture Clinic. You will be asked to sign an additional section on the consent form, verifying that you have received this Notice of Privacy Practices information.

Here is a brief summary of your rights and our policies. Dr. Xie's Acupuncture Clinic may use your record in the following ways:

1. Acupuncturists and qualified personnel may use it to provide you with care.
2. Talk to you about an appointment.
3. Talk to your family or friends with your permission.
4. Help us follow State and Federal regulations and rules.
5. Comply with legal requirements, subpoenas, or court orders.
6. Inform you of other services that may be of benefit to you.
7. Make a request for payment from your insurance company.

Your record is the physical property of Dr. Xie's Acupuncture Clinic LLC.; however, the information contained in the record belongs to you.

You have the rights to:

1. You can review and request a copy of the information used to design and carry out your procedure.
2. You can ask us to amend the information, which you feel is wrong or incorrect.
3. You can ask us to restrict the information we share about you.
4. You can ask us to communicate with you in a certain way or place.
5. You can request a list of who has received your records.
6. You can submit a complaint.

Our goal is to provide the highest quality Acupuncture and Chinese herbal consultation service to you and your family. You have put your trust in us, and we promise to guard that trust. If you have any questions, or need to report a problem, call, Dr. Jinhua Xie at 847-.6308798

Sincerely,

Jinhua Xie PhD LAc,
September 1st 2019

Our Responsibilities

- Maintain the privacy of your information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will e-mail the revised notice to you.

We will not use or disclose your information without your authorization, except as described in this notice. We will also discontinue to use of disclose your information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you believe that Dr. Xie's Acupuncture Clinic personnel have violated your privacy rights in this notice, you may file a complaint with Dr. Xie's Acupuncture Clinic, Office of Privacy, Office of Civil Rights, or with US Department of Health and Human Services. To file a complaint with either entity, please call Dr. Jinhua Xie at (847) 630-8798. Filing a complaint will not affect the services you receive from Dr. Xie's Acupuncture Clinic.

Examples of Disclosures for Services and Procedures

We will use your information for acupuncture service and herbal consultation.
For example: Information obtained by an acupuncturist/herbal consultant or other member of the team will be recorded in your record and used to determine procedures and services that should work best for you. Your consultant will document in your record his or her expectations of the members of the team. Members of the team will then record the actions they took and their observations. In that way, the consultant will know how you are responding to the procedures.

We will use your information for payment. For example: A bill may be sent to your or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your evaluation, procedures, and services used.

We will use your information for improvement of office management. For example: Managers may use information in your record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the service we provide.

Business Associates: There are some services provided in our office through contacts with business associates. We may disclose your information to our business associate so that they can perform the job we've asked them to do. To protect your information, however, we require the business associates to appropriately safeguard you information.

Appointment Reminders: Our clinic may use and disclose your information to contact you and remind you of an appointment.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representation, or another person responsible for you care, you location, and general condition.
Communication with Family: Consultations using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in you care or payment related to you care.

Marketing: We may contact you to provide appointment reminders or information about service alternatives or other related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to FDA information relative to adverse events and respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional Institution: Should you be an inmate of a correctional institution; we may disclose to the institution or agents thereof information necessary for your health and the health and safety of other individuals.

Law Enforcement: We may disclose information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more clients, workers or the public.

Special Situations
Some types of medical and health information are very sensitive. HIPAA protects you from unauthorized release of information such as genetic, HIV/AIDS, mental health, alcohol, and substance abuse, artificial insemination, and sexual assault. In most circumstances this information cannot be released without your express permission or a court's order.

We may be required to release information as ordered by a court, judicial or administrative proceeding. In most cases written permission must be obtained to release documents obtained by healthcare providers and crisis counselors in cases of rape.

If you provide written permission to release information about you, you may revoke that permission in writing at any time. Please understand we cannot take back any information, which has already been released.

Notice of Privacy Practices
This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully. All of the staff will follow this notice and will be collectively known as Dr. Xie's Acupuncture Clinic.

Our Pledge to You
We pledge to keep information that identifies you private.
We pledge to give you notice of our legal duties and privacy practices and notify you if they change.
We pledge to follow the state and federal rules regarding privacy policies.

Introduction
At Dr. Xie's Acupuncture Clinic, we are committed to protecting your information responsibly. This Notice of Privacy Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected information. This Notice is effective October 21, 2013, and applies to all protected information as defined by federal regulations.

Understanding Your Record/Information

Each time you visit our office, a record of your visit is made. Typically, this record contains your symptoms, evaluations and procedures. This information, often referred to as your record, serves as a:

- Basis for consultation and procedure,
- Means of communication among qualified staff members who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your information is used helps you to: ensure it accuracy, better understand who, what, when, where, and why others may access your information, and make more informed decisions when authorizing disclosure to others.

Your Privacy Information Rights

Although your record is the physical property of Dr. Xie's Acupuncture Clinic LLC, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of privacy practices upon request,
- Inspect and copy your record as provided for in 45 CFR 164.524. You must submit your request in writing to Dr. Xie's Acupuncture Clinic at 285 Peterson Rd., Libertyville, IL 60048, Attention: Dr. Jinhua Xie.
- Amend your record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your information as provided in 45 CFR 164.528,
- Request communications of your information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522,
- Revoke your authorization to use or disclose information except to the extent that action has already been taken.

Risk of Bruising

Please be aware that any medical treatment that inserts a needle into the skin can result in bruising. Acupuncture needles are solid pre-sterilized stainless steel with a cone shaped tip. In most cases, they simply push the skin apart and slide painlessly into the tissue. Unlike hypodermic needles which cut the skin with a sharp, tip to insert a liquid, Acupuncture needle are less likely to cause bruising. **However, depending on your current medical condition, the location' of the insertion or the need to stimulate the 'point/ strong sensation and bruising may occur.** In most cases, after the treatment you may feel as if the needle is still inserted even after it has been removed. This is a normal feeling. The stimulation of the points doesn't stop immediately after removing the needle. **If you get home and there is any swelling, bruising or soreness, simply place an ice cube in wet wash cloth and rub in gently on the point for a short time.** Most bruising will go away in a few days, to about a week, if it takes longer; please call the clinic. Some discoloration of the skin may be permanent, but this is rare. All medical procedures have risks and benefits, by signing the patient consent form you are acknowledging these risks.

If you have any question please talk to Dr. Jinhua Xie before beginning your treatment.

ACUPUNCTURE INFORMATION AND INFORMED CONSENT

Acupuncture is performed by the insertion of PRE-STERILIZED, DISPOSABLE acupuncture needles through the skin, and / or the application of heat stimulation to skin, or both, at certain points on the body. The benefits and risks of receiving acupuncture procedure and Chinese herbal consultation have been explained to me. Although rare, certain side effects may result fro Acupuncture, I understand that each procedure or treatment has specific risks and benefits.

I have been informed of the risk and benefits of the procedure and products below that apply to my case: Acupuncture needles to stimulate points and meridians, including the specific risks of needling certain points and the use of mechanical stimulation of acupuncture points or acupressure.

I have been informed and understand the risks and side effects listed below:
1) Minor burning, 2) Needle sickness, 3) Broken needles, 4) Some pain at the site of needle insertion, 5) Infection, 6) The risks from needling in the vicinity of an infection, and 7) Potential side effects of Chinese herbs.

I understand that Dr. Xie's Acupuncture Clinic may record information concerning my treatment in electronic and in other physical form. Such information may be released by Dr. Xie's Acupuncture Clinic for the purposes authorized on this form. I understand that portions of my records may be disclosed to other personnel for the purpose of management, financial audits, and licensure and program evaluation without my express consent. I understand that the practice of Acupuncture and Herbal Consultation is not an exact science and I acknowledge that no guarantees have been made to me. I understand that licensed Acupuncturists perform these procedures.

RECORDS RELEASE AUTHORIZATION
I understand that I am responsible for my bill.
I authorize payment directly to Dr. Xie's Acupuncture Clinic.
I authorize the use of this information to my insurance submissions.
I authorize release of information to all my insurance companies.
I authorize my clinician to act as my agent to obtain payment from my insurance companies.
I permit a copy of this authorization to be used in place of the original.
I direct my previous heath care providers to release medical records to this clinic.
I authorize Dr. Xie's Acupuncture Clinic to make copy of my previous medical information which I have provided.
I authorize the use of my previous medial information to be the basis of acupuncture procedure and herbal consultation.
This authorization is not intended to allow the release of records regarding my treatment for services requiring a restricted release under State or Federal Law.

Client's Name (Print) _____

Client's Signature _____ **Date**_____

NOTICE OF PRIVACY PRACTICES
I have received a copy of Dr. Xie's Acupuncture Clinic Notice of Privacy Practices. I understand this information defines my rights under 45 CFR 164.528 of the federal regulations and is intended to comply with federal patient privacy rights.

Client's Signature _____ **Date:** _____

CONSENT FOR A MINOR PATIENT
I authorize Dr. Xie's Acupuncture Clinic and whomever it designates as assistants to administer Acupuncture procedure and Chinese herbal consultation as deemed necessary to my _____ (relationship).

Minor Client's Name _____

Parent / Custodian's Name and Signature_____ **Date** _____

PATIENT INFORMATION
(Please Print)

Patient's Name: _____ Sex: M _____ F _____
First Middle Last
Date of Birth _____/_____/_____(mm/dd/yy) **Marital Status**: Single _____Married ____Divorced _____Others _____

Address _____ City_____ State_____ Zip _____

Occupation _____E-mail _____@_____

Phone Number: Home _____Work _____ Cell _____

Referred by _____

Employer Information _____

Address _____ City _____ State_____ Zip _____

Emergency Contact
Name _____ Relationship _____

Address _____ City_____ State_____ Zip _____

Phone Number: Primary Number _____ Secondary Number_____

Insurance Information (Please Print):

Insurance Company: _____ **I.D. NUMBER**: _____ **POLICY GROUP #**: _____

Subscriber's Name: _____ Sex: M _ F _ **Date of Birth** ___ __/___ _ /___ (mm/dd/yy) **Phone #**_____

Relationship to Patient: Self_ Spouse _ Child __ Other (specify) _____ **Subscriber's Signature**: _____

Subscriber's Address _____ City _____State_____ Zip _____

Can we send you the following information electronically? Email address: _____**@**_____
- Information about your herbs and supplements? Yes _____ No_____
- Newsletter from Dr. Xie's Acupuncture Clinic? Yes _____ No_____
- Information about potential treatment options or alternatives? Yes _____ No_____
- Appointment reminders? Yes _____ No_____

Family History: Does your mother, father, grandparents, brothers, sisters, aunts, uncles, or children have any of the following? If yes, who? If family history is unknown, please check unknown. ☐ **Unknown/Adopted**
Yes___ No___; Allergy If yes, who? _____
Yes___ No___; Bleeding Disorder If yes, who? _____
Yes___ No___; Cancer If yes, who? _____
Yes___ No___; Depression If yes, who? _____ _____
Yes___ No___; High blood sugar (Diabetes) If yes, who? _____
Yes___ No___; Heart Problems If yes, who? _____
Yes___ No___; High Blood Pressure If yes, who?_____
Yes___ No___; Lung Problems (asthma) If yes, who? _____

Social History:
Substance Abuse: _____
Cigarette Smoking? Yes___ No___; Packs Per day: _____How long? _____
Past smoking? Yes___ No___; What year did you quit? _____
Smoke Exposure? Yes___ No___;
Do you drink alcohol? Yes___ No___; How many alcoholic drinks per week? _____
Any drug use? Yes___ No___; What type of drug? _____

Living Situation:
Are there pets in the home? Yes___ No___; If yes, what type of pet: _____
Exercise: Yes___ No___; If yes: _____x/week Type: _____
Diet: ☐ Regular ☐ Diabetic ☐ Low Fat ☐ Low Salt ☐ Other: _____ **Hobbies** _____ _

Review of Systems: Please check the "Yes" or "No" box to indicate if you have any of the following symptoms. For any "Yes" response, please check the "current" box if this symptom relates to the reason for your visit today.

	Yes	No	Current
General			
Chills	□	□	□
Fever	□	□	□
Fatigue	□	□	□
Night sweating	□	□	□
Weight gain/ loss	□	□	□
Daytime sleepiness	□	□	□
Sleeping difficulties	□	□	□
Allergy			
Environmental allergy	□	□	□
Sneezing	□	□	□
Dermatology (Skin)	□	□	□
Rash	□	□	□
Inching	□	□	□
Hives	□	□	□
Changes in Moles	□	□	□
Scalp problems	□	□	□
Hair changes	□	□	□
Bruising	□	□	□
Yellowing of skin	□	□	□
New lesions	□	□	□
EYES			
Eye pain/pressure	□	□	□
Visual disturbances	□	□	□
ENT			
Ear ache	□	□	□
Ring in ears	□	□	□
Dizziness	□	□	□
Decreased hearing	□	□	□
Nasal congestion	□	□	□
Nose bleeding	□	□	□
Snoring	□	□	□
Throat clearing	□	□	□
Sore throat	□	□	□
Throat hoarseness	□	□	□
Respiratory			
Cough	□	□	□
Wheezing	□	□	□
Shortness of breath	□	□	□
Coughing up blood	□	□	□
Sputum production	□	□	□
Breast			
Breast Lump	□	□	□
Breast pain	□	□	□
Nipple discharge	□	□	□
Gastrointestinal			
Difficulty in swallowing	□	□	□
Heartburn	□	□	□
Nausea	□	□	□
Abdominal pain	□	□	□
Stomach pain	□	□	□
Constipation	□	□	□
Diarrhea	□	□	□
Black, tarry stool	□	□	□
Female Genitourinary			
Vaginal bleeding problem	□	□	□
Pelvic pain	□	□	□
Urinary complaints	□	□	□
Vaginal discharges	□	□	□
Male Genitourinary			
Blood in urine	□	□	□
Urination difficulty	□	□	□
Neurological			
Dizziness	□	□	□
Faintness	□	□	□
Headache	□	□	□
Memory problems	□	□	□
Seizures	□	□	□
Tremors	□	□	□
Weakness of limbs	□	□	□
Psychiatric:			
Anxiety	□	□	□
Mood swing	□	□	□
Depression	□	□	□
Change in sleep pattern	□	□	□
Endocrine:			
Appetite change	□	□	□
Excessive thirsty	□	□	□
Hot flashes	□	□	□
Hematology			
Anemia	□	□	□
Blood clots in legs / lungs	□	□	□
Easy bruising	□	□	□
Bleeding problem	□	□	□

Medications, Herbal and Other Supplements

Are you presently taking any of the following medications? Or you may provide us a list of medications you are currently using during your visit.

Medications	No	Yes	Dosage and Frequency
Analgesics (Aspirin, Ibuprofen, Naproxen, Sodium, etc.)			
Cardiovascular Agents (Digoxin, Lanoxin, Captopril, etc.)			
Laxatives			
Antacids (Bicarbonate of Soda, Calcium Carbonate, etc.)			
Sedative, Antianxiety, Antipsychotic drugs (Lithium, Thioridazine, Chlorpromazine, Prozac, etc.)			
Anti-Inflammatories (Predinisone, other corticosteroids, NSAIDs, etc.)			
Respiratory Agents (Theophylline, etc.)			
Diuretics (Lasix)			
Antibiotics			
Elixirs containing sorbitol (Theophylline, Acetaminophen, etc.)			
Insulin or Diabetic Pills			
Sleeping Pills			
Thyroid Medication			
Blood-thinning Pills			
Seizure Medication			
Weight Reducing Pills			
Birth Control Pills			
Hormones			
Blood Pressure Pills			

List other (including over-the-counter medications) you currently use:

List herbal, or other natural supplements, vitamins and minerals you currently use:

Allergies: (List allergen name and the type of reaction, write n/a if none)

Medication (s): _____ Reaction: _____

Food/Insects/Other: _____ Reaction: _____

Chinese Medicine Consultation Review

WHAT ARE YOUR Current COMPLAINTS?

#1_____How long?_____

#2_____How long?_____

#3_____How long?_____

Please check the appropriate descriptions and fill in the necessary information:

Emotions: depress ____ sad ____ panic attack ____ anger ____ anxiety ____

Energy: low ____ exhausted ____ hyperactive ____

Sleep Pattern: have difficulty falling asleep _____; wake up _____ (times per night); Wake up too early ____; cannot go back to sleep after waking up _____

Temperature: fever ____ cold hands ____ cold feet ____ hot flash ____

Sweating: too little ____ too much ____ night sweats ____

Sensitive or Allergic to: cold ____ hot ____ dampness ____ dust ____ hay ____ pollen ____ food _____others _____

Appetite & Digestion: poor appetite ____ rapid hungering ____ craving _____nausea ____ bloating ____ gas ____

Bowel Movement: constipation ____ diarrhea ____ loose ____ watery ____ incomplete defecation ____ hard and dry ___ strong smell ____ with mucous ___ with blood ____, time of day when BM occurs: ____

Body Weight: Overweight __ Underweight ___ How many pounds would you like to gain or lose? _____

Liquid Intake: dry mouth ____ thirsty __ drink a lot of water___ not thirsty, but drink a lot of water anyway ____

Urination: frequent ____ urgent ____ burning ____ painful ____ cloudy ____ dark color ____ foul smell ____ retention ____ bloody ____ number of times per day: _____ number of times per night: _____

Menstrual Cycle and Pregnancy (Female patient only):

Pregnant: Yes_____ No _____

Last Menstrual Period: From _____ to _____

Average days of the cycle _____, days of period _____ clots _____ menstrual pain _____ , menstrual color: pale red _____ bright red _____ or dark red _____

Emotion around menstrual period: depression ____ irritability ____ anger ____ crying ____ anxiety ____ others: _____

Emotions occur: before period ____ during period ____ after period ____

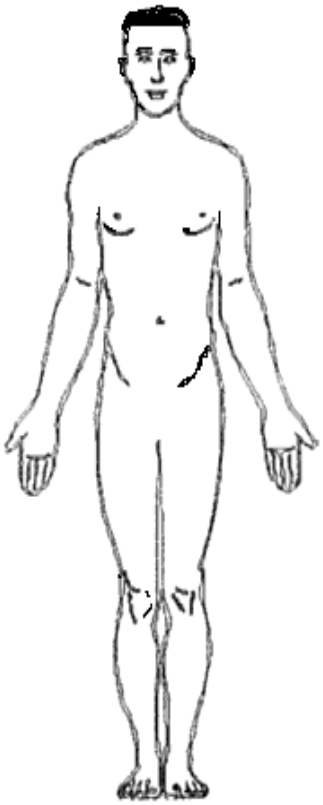
Is there any additional information you would like your acupuncturist to know?

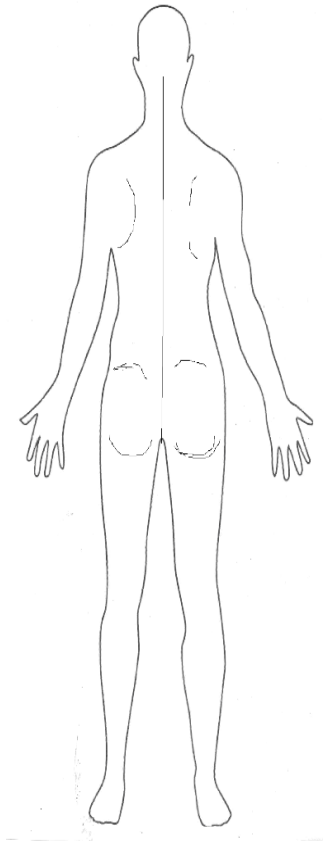
For patient with any pain and related condition(s), please check the appropriate boxes below and mark on the figures.

Location of Pain	Scores (1-10)	Duration	Constant /intermittent	Stabbing	Heavy	Sore	Dull	Burning	Numb/Tingling
Headache									
Jaw									
Upper back									
Middle back									
Lower back									
Chest									
Neck									
Shoulders									
Upper Arm									
Elbows									
Forearm									
Wrists									
Hands									
Buttocks									
Thighs									
Knees									
Legs									
Ankles									
Foot									

Please also mark your conditions on the figure below for location of pain and sensation.

Pain: *X*, Spasm: S, Numbness: N, Weakness: W, Cold Sensation: C, Burning Sensation: B, Heavy Sensation: H





Used by the acupuncturist Only:

Tongue

Pulse:

TCM Assessment:

Acupuncture Session 1:
Face to Face time:
Points:

Acupuncture Session 2:
Face to Face time:
Points:

Additional Treatments
Infra-red heat:
Cupping:
TuiNa/Stretching:
Exercise:

Signature:
Date:

COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided) — Initial Below

I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. _____

I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____

I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. _____

I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:

*Fever	*Dry Cough	*Sore Throat
*Shortness of Breath	*Runny Nose	*Loss of Taste or Smell

_____

I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. _____

I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____

I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient	Parent / Guardian	Witness
Signature: _____	Signature _____	Signature _____
Name _____	Name _____	Name: _____
Date _____	Date _____	Date: _____

The form is provided by courtesy of The American Acupuncture Council.