

**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 from 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 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.

**Patient's Name (Print)** \_\_\_\_\_

**Patient'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. I have been notified that an electronic copy of this Notice of Privacy Practices can be downloaded from <https://www.acupunctureforhealthcare.com/notice-of-privacy-practices/> if I prefer.

**Patient'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 Patient's Name** \_\_\_\_\_

**Parent / Custodian's Name and Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**PATIENT INFORMATION (Please Print)**

Patient's Name: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_

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 via email and cell phone text message?**

Email address: \_\_\_\_\_ @ \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

- Appointment reminders? Yes \_\_\_\_\_ No \_\_\_\_\_
- Information about your herbs and supplements? Yes \_\_\_\_\_ No \_\_\_\_\_
- Invoice and billing statements? 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**

- Allergy Yes \_\_\_\_\_ No \_\_\_\_\_; If yes, who? \_\_\_\_\_
- Bleeding Disorder Yes \_\_\_\_\_ No \_\_\_\_\_; If yes, who? \_\_\_\_\_
- Cancer Yes \_\_\_\_\_ No \_\_\_\_\_; If yes, who? \_\_\_\_\_
- Depression Yes \_\_\_\_\_ No \_\_\_\_\_; If yes, who? \_\_\_\_\_
- Diabetes/Prediabetes Yes \_\_\_\_\_ No \_\_\_\_\_; If yes, who? \_\_\_\_\_
- Heart Problems Yes \_\_\_\_\_ No \_\_\_\_\_; If yes, who? \_\_\_\_\_
- High Blood Pressure Yes \_\_\_\_\_ No \_\_\_\_\_; If yes, who? \_\_\_\_\_
- Lung Problems (asthma) Yes \_\_\_\_\_ No \_\_\_\_\_; If yes, who? \_\_\_\_\_

**Social History:**

- Cigarette Smoking? Yes \_\_\_\_\_ No \_\_\_\_\_; Packs Per day: \_\_\_\_\_ How long? \_\_\_\_\_
- Past smoking? Yes \_\_\_\_\_ No \_\_\_\_\_; When did you quit? \_\_\_\_\_ Smoke Exposure? Yes \_\_\_\_\_ No \_\_\_\_\_;
- Do you drink alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_; How many alcoholic drinks per week? \_\_\_\_\_
- Substance Abuse of drug use? Yes \_\_\_\_\_ No \_\_\_\_\_; If yes, then what type of substance or drug? \_\_\_\_\_

**Living Situation:**

- Are there pets in the home? Yes \_\_\_\_\_ No \_\_\_\_\_; If yes, what type of pet: \_\_\_\_\_

Exercise: Yes \_\_\_\_\_ No \_\_\_\_\_; If yes: \_\_\_\_\_ times/week; Type of exercise: \_\_\_\_\_

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

### 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 (Prednisone, 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

#### Current Complaints:

#1 \_\_\_\_\_ For How long? \_\_\_\_\_

#2 \_\_\_\_\_ For How long? \_\_\_\_\_

#3 \_\_\_\_\_ For 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 \_\_\_;

Not able to 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 \_\_\_\_\_

**Menstrual Cycle:** Average days of the cycle \_\_\_\_\_, days of period \_\_\_\_\_ clots \_\_\_ menstrual pain \_\_\_\_\_,

**Menstrual Color:** pale red \_\_\_ bright red \_\_\_ or dark red \_\_\_

**Emotion around the period:** depression \_\_\_ irritability \_\_\_ anger \_\_\_ crying \_\_\_ anxiety \_\_\_ others: \_\_\_\_\_

**Emotions occur:** before the period \_\_\_ during the period \_\_\_ after the period \_\_\_

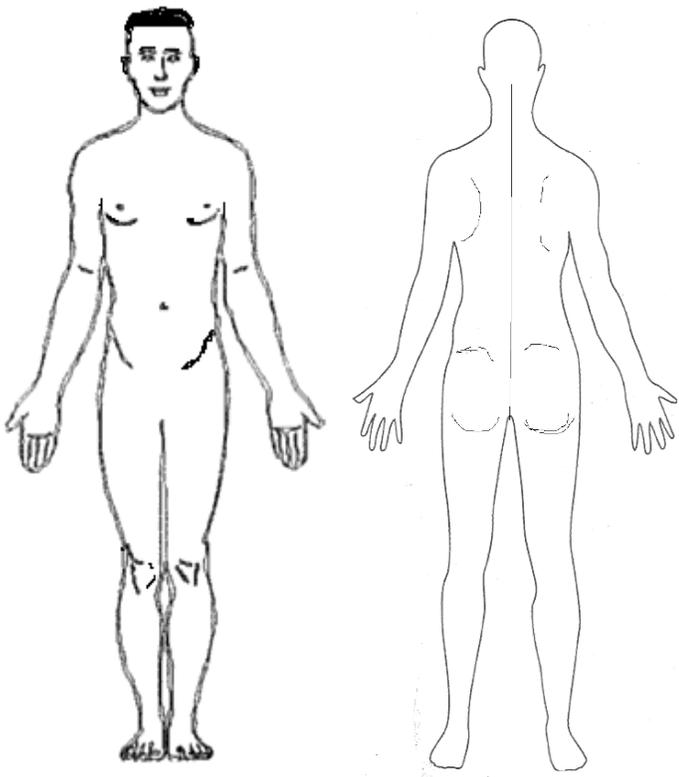
**Is there any additional information related to your health conditions you would like your acupuncturist to know?**

**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:
<b>Acupuncture Session 1:</b>
Face to Face time:
Points:
<b>Acupuncture Session 2:</b>
Face to Face time:
Points:
<b>Additional Treatments</b>
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.

**Initial  
Below**

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

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's Name** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Minor Patient's Name** \_\_\_\_\_

**Parent / Custodian's Name and Signature** \_\_\_\_\_ **Date** \_\_\_\_\_