

Cody Acupuncture Clinic, Inc.
Rosemary Cody, L.Ac.
Phone (208) 720-7530

INFORMED CONSENT AND CLINIC POLICY AGREEMENT

Please read the following information carefully:

Properly administered acupuncture and herbal medicine by a Licensed Acupuncturist is safe and generally very effective. Rosemary Cody, L.Ac. is National Board Certified in Acupuncture (NCCAOM) and licensed by the State of Alaska and Idaho. It is my clinic policy to use only sterile, single use, disposable needles. Occasionally, minor side effects such as small bruises, marks to the skin, emotional factors, or a temporary exacerbation of symptoms may occur. As with any foods or medications, there are similar risks of allergic reactions to herbal, homeopathic or nutritional supplements. If you have a history of serious allergic reactions to foods, insects or other substances, please be sure that it is noted on your medical history.

If you are pregnant or think you may be pregnant it is imperative that you discontinue any previously prescribed herbal formulas and notify me prior to any additional treatment. Traditional Oriental Medical Medicine is not a substitute for regular medical exams by a primary care provider such as a Medical Doctor (M.D.) If a serious health problem arises, a second medical opinion may be required before further treatments will be administered.

I, _____, have read and understand the above information. I realize, as with any form of healthcare, there is no guarantee of success with these treatments. I willingly agree to participate in the recommended treatments with full knowledge and consent and accept financial responsibility for my sessions. I understand that payment is required at the time of services unless prior arrangements have been made. There will be a \$25 fee for any returned checks. For appointments not canceled within 24 hours of my appointment time I agree to pay a LATE CANCELLATION FEE of \$50. If I miss a scheduled appointment without any prior notice, I understand that the FULL COST of my visit will be charged.

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

This form acknowledges that a copy of our Notice of Privacy Practices has been provided to me in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this office, the individual rights I have regarding my health information and how to exercise them and the legal responsibilities the practice has with respect to the protection of that information. This practice reserves the right to change the terms of this Notice as appropriate or according to changes in the law. I understand that I can get a copy of this practice's current Notice of Privacy Practices upon request.

Patient Name (please print): _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature (for Minor): _____