

Shining Sea Acupuncture, LLC
Kathleen L. Rebeck, M.Ac., L.Ac.
1306 North Atlantic Avenue
Southport, NC 28461
910-599-3081

Information & Consent to Services

SERVICES TO BE PROVIDED

I understand that acupuncture serves individuals with a wide range of complaints including both acute and chronic healthcare issues. I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, and gua sha.

NO GUARANTEES

I know that each person is unique and has ultimate responsibility for his or her own healthcare. I acknowledge that I have not received any guarantees or promises as to the results or success that will be obtained from the services provided.

INFECTIOUS DISEASE PREVENTION

I understand that infectious diseases are carried through the air, through physical contact, and through body fluids. I understand that Shining Sea Acupuncture, LLC follows universally prescribed precautions and procedures (such as clean needle technique and hand washing) to prevent the spread of infectious disease.

RISKS/POSSIBLE SIDE EFFECTS/HEALING RESPONSE

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects including bruising, slight bleeding, fainting, temporary pain and discomfort, and temporary aggravation of symptoms existing prior to treatment. Unusual side effects of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

MEDICAL TREATMENT

I recognize that an acupuncturist is not a substitute for a medical doctor and will not suggest that I discontinue medical treatment. I am free to consult a medical doctor or any other licensed practitioner at any time. I understand also that if there is an emergency, or a worsening of my health condition, or if a new ailment or condition arises, that I should consult a licensed physician.

CLIENT RESPONSIBILITIES

I understand that it is my responsibility as a client to inform my practitioner about all aspects of my health and that, as service progresses, to inform my practitioner of changes that occur. If I experience any pain, discomfort, or possible adverse side effects, it is my responsibility to immediately notify my practitioner.

FEES & CHARGES

I have been informed of the fees for service, and I understand that payment is due when the services are provided. **If I do not cancel an appointment at least 24 hours in advance, then I am liable for the fee.**

By voluntarily signing below I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions, which were answered to my satisfaction. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Client Signature
(or representative)

Relationship
(if signing as representative)