

Acupuncture Informed Consent

I hereby request and consent to the performance of acupuncture and/or Chinese herbal treatments and other procedures within the scope of acupuncture on me (or the patient named below, for whom I am legally responsible) by the acupuncturist, named below and or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as a back-up for the acupuncturist named below.

This clinic complies with the rules and regulations promulgated by the Colorado Department of Public Health and Environment, including the use of single-use, sterile needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are used in this clinic. There are some risks to treatment including but not limited to some bruising of the skin and/or slight bleeding.

The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Acupuncturists Licensure Office, 1560 Broadway, Suite 1340, Denver, CO 80202. Telephone (303) 894-7851.

I have had an opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture. I understand that the results are not guaranteed.

Patient Rights

- The patient is entitled to receive information about methods of therapy, the techniques used, and the duration of therapy, if known.
- The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.
- In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

I have read, or have had read to me, the above consent and have had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend for 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.

Patient Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

Cecily Yousaf, MSOM, L.Ac.

Licensed Acupuncturist and Owner of Fertile Ground

Acupuncture Fee Schedule

Adults	Couples	Lactation	Pediatrics
New patient: \$120.00	\$120.00	New patient: \$70.00	Infant-3 years: \$60.00
Return visit: \$70.00		Return visit: \$60.00	

The first office visit is 1-1.5 hours in length, return office visits are generally 1 hour in length.

Signature

Please indicate your understanding and acceptance of the acupuncture fee schedule:

Signed _____ Date _____

Acupuncture Disclosure Form

Please check and initial the following to indicate you have read and understand the information in the Acupuncture Disclosure Form and accept the policies therein: Initials

Acupuncture Disclosure Form _____