DEANNA CARELL
acupuncture
181 Franklin Avenue, Suite 302
Nutley, NJ 07110
973.661.1652

ACUPUNCTURE INFORMED CONSENT

I, (print) _____ the undersigned understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, gua sha, tui na (Chinese massage) and nutritional counseling.

I understand that acupuncture, moxibustion, electrical stimulation, cupping, gua sha and tui na, are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and sores at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting, nerve damage, organ puncture, including lung puncture (pneumothorax), spontaneous miscarriage and possible worsening of symptoms. Infection is possible, although the practice uses alcohol and sterile disposable needles and maintains a safe and clean environment. Clean needle technique is always employed. Potential risks of moxibustion heat therapy are burns, blistering or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha. I fully understand that there is no implied or stated guarantee of success of effectiveness of a specific treatment or series of treatments.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant.

I understand that my acupuncturist may review my medical records and lab reports, but all my records will be kept confidential. If it becomes necessary to share my health information, this will be handled in accordance with the stipulations detailed in the Notice of Privacy Policies document that has been provided to me, and of which I have acknowledged the receipt.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment, and healthcare operations received, incurred or carried out at this practice.

By signing below, I show that:

- I have read, or had read to me, the information on this consent form
- I understand the possible risks and complications involved. I have had the opportunity to discuss the consent form with my Acupuncturist. I understand that I can request more information at any time if desired.
- I consent to receive treatment that involves the above procedures.
- I understand that I have the right to refuse of discontinue any treatment at any time. I understand that refusal or discontinuation of treatment should be done in writing and will be kept in my medical file. I understand this refusal may effect the expected results.

X _____
Signature of Patient or Parent/Guardian if minor Date

Witnessed by Staff: _____ Date: _____

DEANNA CARELL

acupuncture

Payment Acknowledgement Form

I, (print)_____, acknowledge that I am responsible for any "out of pocket" cost for services rendered at Deanna Carell Acupuncture. I acknowledge that I have provided my credit card information for payment of services rendered.

(initial) _____ If you have insurance you will provide a copy of your active insurance information.

(initial) _____ I acknowledge that I am responsible for my co-insurance payment at the time of visit. I am aware and acknowledge that verification of insurance coverage and benefits does not guarantee payment by my insurance company for my visits. If, for any reason, my insurance company denies payment, I understand that I am liable for all charges incurred.

(initial) _____ If your insurance company sends checks made payable to you, the member, for your visits and you do not pre-pay for your visit you acknowledge that you owe payment for the visit. If you do not pay your insurance reimbursement payment in a timely manner your credit card on file will be used to cover this payment.

(initial) _____ Failure to make timely payments will result in your credit card on file being charged for any outstanding balance. Any outstanding balance that is unable to be charged with the credit card on file, will then be sent to our lawyer for collections.

(initial) _____ I understand and acknowledge that Deanna Carell Acupuncture has a 24 hour cancellation policy and that any appointment not cancelled or rescheduled within 24 hours will be charged the full visit fee.

(initial) _____ I understand that any returned checks will be subject to a $20 processing fee. Failure to replace and pay all returned checks and the processing fee could result in the unpaid balanced being sent to our lawyer for collections.

X _____

Signature of Patient or Parent/Guardian if minor Date