LEVIN 道 THERAPEUTICS

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Patient's Rights, Acupuncture Informed Consent and Cancellation Notice

Patient Rights Notice

Each patient who visits this office is entitled to receive information about the methods of therapy, the techniques used, and an estimated 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 Pennsylvania State Board of Medicine, P.O. Box 2649, Harrisburg, PA 17105-2649. Phone - (717) 783-1400 Fax - (717) 787-7769 *ST-MEDICINE@PA.GOV*

I have read and understand the above disclosure statement. I understand my rights and responsibilities as a patient. _____ (initial here)

Acupuncture Informed Consent Notice

Acupuncture has been explained to me as a treatment consisting of the insertion of needles through the skin at specific points on the surface of the body (small amounts of electrical current may be applied to the needles). The purpose of acupuncture has been explained as the alleviation or cure of symptoms or disorders.

Acupuncture, acupressure, Moxa, cupping therapy, allergy elimination technique, nutritional or herbal counseling are considered experimental procedures and are not considered a substitute for Western Medicine. Therapies and advice offered shall not be construed by the client to be a diagnosis of treatment of any disease or injury. We recommend that you CONSULT YOUR PHYSICIAN for any serious conditions and receive at least two medical opinions. It is your right and responsibility for your own body.

I understand that complications may result from acupuncture treatment. Among these possible complications are: areas of anesthesia, fainting, weakness, nausea, hematoma, infection, pain and discomfort, pneumothorax, and aggravation of present symptoms. Being hungry, tired, or stressed can infrequently make the body more sensitive to the acupuncture treatment. Please tell your provider if you have any conditions that may inhibit blood clotting, such as hemophilia or Coumadin use. Please use caution when walking with bare feet in the treatment room.

I further understand and agree to hold harmless, to indemnify and to protect against court action the individual therapist as well as the management and owners of this clinic, in the event of accidental injury on these premises. _____ (initial here)

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Patient Cancellation - Payment Notice

Please be considerate of your appointment time. We make every effort to respect your time and see you promptly when you are scheduled. Please call if you cannot make your appointment or you are running late. Patients who consistently miss their appointments or fail to cancel 24 hours in advance may be charged for their missed appointments.

I have read and understand the above Informed Consent statement. I agree to the conditions set forth in this statement. _____ (initial here)

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS. I AGREE TO THE CONDITIONS SET FORTH IN THESE STATEMENTS.

PATIENT NAME (PLEASE PRINT): _____

SIGNED: _____ DATE: _____

SIGNATURE (PATIENT, OR PARENT/LEGAL GUARDIAN OF PATIENT)