Dr. David Orman
Acupuncture Physician
AP#559

Acupuncture Patient Consent Form

PLEASE INITIAL EACH STATEMENT AFTER READING IT

- I hereby request and consent to the performance of acupuncture treatments and other Oriental medicine procedures on me (or on the patient named below, for which I am legally responsible) by the below-named licensed acupuncturist.
- I understand that methods or treatments may include, but are not limited to, acupuncture, moxibustion, cupping, bloodletting, electrical stimulation, Tui Na (Chinese massage), Chinese herbal medicine and nutritional counseling.
- I understand that acupuncture, with or without herbs, is not meant to replace conventional biomedicine, should my case warrant it. I further understand that any Western diagnosis of my condition must be performed by a licensed physician and that I shall be responsible for consulting with the necessary physician(s). I further understand that Dr. David Orman makes no claim about curing my condition.
- I understand that Dr. David Orman will take all possible measures to keep my personal information confidential. May it be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and /or to share appropriate medical information, my signature gives my practitioner permission to release my medical records for the reasons listed above.
- I agree to have Dr. David Orman, I contact me over the phone or by e-mail about appointment time(s).
- I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.
- I agree to pay full charge for any missed or forgotten appointments without 24 hours notice of cancellation.
- I agree to pay full charges incurred for services rendered, over and above insurance coverage.

	To be completed by the patient's representative, if the patient is a minor or is physically or legally incapacitated.
Patient's Name	
Patient's Signature	**Name of Patient**
Date Signed	**Patient's Representative**
	Relationship or Authority to Patient
Date Signed	**Witness**