ANCIENT WISDOM HEALING ARTS
Acupuncture & Herbal Clinic

Dr. Jacob Wilcox, DOM, L.Ac.
1442 S. St. Francis Dr, Suite B
Santa Fe, NM 87505
585 210.2781
AncientWisdomHealingArts.com

Name _____ Date of Birth _____

CONSENT FOR TREATMENT

I herby request and voluntarily consent to receiving acupuncture treatments, which consist of inserting fine, sterile needles through the skin into the underlying tissues. An acupuncture treatment may also involves treatment modalities that may be unfamiliar to you. **I understand I have the right to informed consent prior to being treated with them and have the right to refuse any of them at any time for any reason.** These modalities may include, but are not limited to, the use of cuppng, gua sha, heat therapy, tui na (Chinese massage), electrical stimulations, diet and nutritional counseling, and herbal products (raw and prepared forms).

I fully understand that the risks of acupuncture treatments, although limited and rare, could include the following: minor bruising and burns, minor pain at the needle site, dizziness or faintness. I understand and accept these risks involved in treatment.

If I use a pacemaker, am taking drugs, supplements, and/or herbs I agree that I will inform the practitioner before beginning the treatment.

Initial here _____ Pregnancy: I will notify the acupuncturist should I become pregnant or if I am in the process of trying to become pregnant so the my practitioner points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

I understand that because acupuncture works within the entire body to restore balance, acupuncture may affect people on all levels: physical, emotional, mental, and spiritual. I do not expect Dr. Jacob to be able to anticipate and explain all possible risks and complications of treatment. I understand that the duration of treatment varies from person-to-person depending on the specific illness and body constitution. I fully understand that there is no stated or implied guarantee of success or effectiveness after a specific treatment or series of treatments. I state that I have completed the patient information form completely and accurately. **I have been informed that I have a right to refuse any form of treatment or to stop treatment at any time for any reason.**

_____ _____
Patient Signature (or authorized representative) Date

FINANCIAL AGREEMENT & APPOINTMENT CANCELLATION POLICY

We would like to take a moment to welcome you to our office and familiarize you with our financial policy and your responsibilities.

Payment for Services:
Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance. Returned checks will be charged a $30 fee.

Insurance:
I am not a participating provider nor in network with any insurance company. As a courtesy, upon request, I am able to provide you with a super bill for you to submit to you insurance company for reimbursement, however we hold no responsibility concerning any actual insurance reimbursement and or communication with your insurance company.

Appointment Cancellation Policy:
Please be aware that a specific amount of time has been set aside for your treatment. Arriving late means that your treatment will be adjusted to fit into the time scheduled. We require 24 hours notice of intent to cancel or reschedule your appointment, except in case of emergencies. Missed appointments will be charged a $40 cancellation fee.

My signature below constitutes acknowledgement and acceptance of this policy.

_____ _____
Patient Signature (or authorized representative) Date