origins
ACUPUNCTURE & WELLNESS

Consent to Treat Minors

Patient Name: _____

I hereby request and authorize **Melissa Graf, L.Ac.** to perform treatment to _____.

I, the undersigned, do hereby request and consent to the performance of acupuncture and chinese medicine treatment and related therapy procedures upon the above-named patient (my dependent). I wish to rely on the acupuncturist to exercise judgment for my best interest during the course of treatment. I will inform the acupuncturist or assistant who is treating my child of any sensitive areas or adverse conditions my child have had prior to, during, or after treatment. I intend this consent to cover the entire course of treatment. I recognize that the practice of acupuncture is not an exact science and I acknowledge that no guarantees have been made to me as to the result of services administered to my child in connection with this Agreement. I understand as with any health care procedure that certain complications my rarely occur such as needle sickness, pneumothorax, or bruising.

I understand payment is expected at the time of the visit. Any other arrangements, including direct insurance billing, payment plan or deferral, must be made in writing through the front desk. Verbal agreements are not acceptable. I realize a notice of 24 hours is encouraged for cancelled appointments. Therefore, canceling as early as possible is greatly appreciated to allow others the time slot.

I hereby authorize the release of my child's medical records and other information necessary to process insurance claims.

I clearly understand and agree that all services rendered to my dependent, the above-named patient, are charged directly to me and that I am personally responsible for payment. I understand that even if I suspend or terminate the treatment, any fees for professional services rendered to me will be immediately due and payable.

As of the date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/ former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Date: _____ _____

Adult Printed Name Adult Signature

Witness Signature _____

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