NO SHOW/LATE CANCELLATION POLICY: As a courtesy to other clients and Chiropractors, we ask that you give a 3 hour notice if you cannot make it to your scheduled appointment. Our policy is to charge for missed appointments at the rate of the scheduled visit, billed directly to you, and payable prior to your next visit. SGI, FHB, and WCB do not cover the cost of a missed appointment. Please help us serve you better by keeping scheduled appointments. Thank You. **I have read, understood and agree to the above financial policy.**

Signature: _____Date: _____

DR. NOTES

INNOVATION WELLNESS

Informed Consent to Acupuncture Care

Please Read Carefully

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, as necessary, and including electroacupuncture by Dr. Kyle Roth.

I understand and am informed that in the practice of acupuncture there are some **Risks to Treatment** including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.

*** The following **DO NOT** exist in my current state of health and I will immediately notify the practitioner of any changes:

> Taking **blood thinners/anti-coagulants**
> Have a **bleeding disorder**
> Have a **Local Infection**
> Have a **blood borne disease**
> Have any **metal** plates/rods/screws/etc in your body
> Are at **Elevated Risk of Infection**
> Have an **internal heart defibrillator or pacemaker**

I have been advised that only pre-sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of the treatment which the doctor feels at the time, based upon the facts then known, is in my best interests. I understand that the results are not guaranteed.

I have read the above consent form thoroughly. I have also had an opportunity to **ask questions** about its content, and by signing below I agree to the above mentioned acupuncture procedures. I intend this consent form to cover the entire course of treatment for my present and future conditions for which I seek treatment.

Female Patients:

Are you, or might you be, pregnant? Yes ___ No ___

If you are pregnant, how far along are you? _____ Weeks

If you are pregnant, have you experienced any spotting? Cramping? Complications thus far? Yes ___ No ___

Do you have any prior history of Miscarriages? Complications? Spotting? Difficulty conceiving? Etc. Yes ___ No ___

I fully understand that in the case of **pregnancy**, a **risk** of causing fetal distress with acupuncture treatment(s) is possible.

READ BEFORE SIGNING

_____	_____	_____
Date Signed	**Print Patient's Name**	**Signature of Patient**