

Acupuncture - Informed Consent

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Dr. Danny Lai, D.C., L.Ac. I understand that there are some minor risks to acupuncture treatment, including, but not limited to some slight bruising of the skin (hematoma) and/or slight bleeding. I understand that the risk of infection is negligible when all needles are sterile. I have had an opportunity to discuss with the Acupuncturist named herein and/or with other office or clinical personnel the nature and purpose of acupuncture. I understand that results are not guaranteed. I do not expect the Acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the Acupuncturist to exercise judgment during the course of the procedure which the Acupuncturist feels at the time, based upon the facts then known, is in my best interests. 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.

About Your Treatment

1. We use only sterile, single-use disposable needles.
2. Sometimes, after receiving an acupuncture treatment, you may feel a little bit light headed. If that happens, please sit for a while in the waiting room. In a few minutes you'll feel fine.
3. Herbal prescriptions and herbal patent medicines are intended only for the person for whom they are dispensed. Because of the individualized nature of herbal prescriptions, we cannot restock them.

Chiropractic - Informed Consent

When a patient seeks chiropractic health care, and when a chiropractor accepts a patient for such care, it is essential that both are seeking and working for the same goals. Chiropractic is not a substitute for medical treatment. Chiropractic has only one goal: **TO LOCATE, ANALYZE AND CORRECT SPINAL INTERFERENCE TO THE NERVOUS SYSTEM.** The purpose of the nervous system is to control and coordinate all bodily functions. Interference to this master system automatically produces improper function in the body. The **SUBLUXATION** (spinal misalignment producing nerve interference), in and of itself, is a detriment of life and health. Correction of the subluxation through a specific chiropractic adjustment, allows the body to function at its optimum level. This allows the **INNATE** healing power of the body to work at maximum efficiency to restore, maintain, and promote health.

**WE DO NOT DIAGNOSE CONDITION(S) OF DISEASE(S) OTHER THAN VERTEBRAL SUBLUXATIONS.
WE OFFER NO TREATMENT OF CONDITION(S) OR DISEASE(S) OTHER THAN VERTEBRAL SUBLUXATIONS.
WE PROMISE NO CURE OF FORM ANY CONDITION ANY CONDITION(S) DISEASE(S).
THE CHIROPRACTIC ADJUSTMENT RESTORES LIFE AND HEALTH TO ITS FULLEST POTENTIAL!**

I do hereby consent, authorize and request Dr. Danny Lai to administer chiropractic care deemed advisable, necessary, or requested.

_____ X _____
Date Printed Name Patient Signature (or guardian, if minor)

HIPPA – Notice of Privacy Practices

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide **DC Chiropractic** with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____ X _____
Date Printed Name Patient Signature (or guardian, if minor)

Consent to Treat a Minor

I (we) being the parent or guardian of _____ a minor, the age of _____ do hereby consent, authorize, and request Dr. Danny Lai, to administer such treatment deemed advisable, necessary or requested on the above minor.

_____ X _____
Date Printed Name Patient Signature (or guardian, if minor)

I certify that the above information is complete and accurate to the best of my knowledge. I understand that I am liable for all charges for services rendered and I agree to notify the doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

I understand there will be a \$15 charge to my account for missed appointment without a 24 hours notice. Payment is expected when services are rendered unless other arrangements are made in advance.

Patient Signature _____ Date _____