Michelle Belanger, A.P.
Acupuncture Physician and Herbalist
450 North Park Road #401
Hollywood, Fl 33021
954-243-9954

Consent To Treatment

I, _____, voluntarily consent to be treated with Acupuncture.

I understand that the Acupuncture will be performed by the insertion of sterile, disposable needles through the skin, or by the application of heat, or by some combination of the foregoing, at certain points on my body; and that such treatment is intended to improve body function and relieve pain.

I have been informed that although rare, side effects may result from my Acupuncture treatment. These could include some minor pain or discomfort, localized bruising, fainting, nausea and the temporary aggravation of pre-existing conditions. I accept that NO Guarantee is made concerning the results of my Acupuncture treatment, and I have been informed that I may stop treatment at any time. I will inform my practitioner if I am or become pregnant.

Release of Information

I consent also to the submission of any data relating to my Acupuncture treatments to any health insurer with whom I have coverage, and understand that this does not otherwise waive my right to confidentiality of my records. I consent to the use and disclosure of my protected health information for treatment, payment or clinic operations. I understand that I have the right to revoke this consent, in writing, at any time. However, the revocation will not affect any disclosures made in reliance of my prior consent.

Notice of Privacy Practices and Patient Rights

I acknowledge that I have received a copy of the Notice of Privacy practices and Patient Rights and have had the opportunity to ask questions about it. All questions I have asked have been fully answered.
The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The practice has a Notice of Privacy Practices and the patient has had a chance to review this notice.
- The practice reserves the right to change the notice of privacy policies.
- The patient has the right to restrict the uses of their information but the practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The practice may condition treatment upon execution of this consent.

_____ _____
Patient Name (Print) Date Signed

_____ _____
Signature of Patient (or Guardian) Date Signed

_____ _____
Witness Date Signed