CONSENT FORM FOR ACUPUNCTURE
OPTIMUM ACUPUNCTURE & CHIROPRACTIC CLINIC
Christine A Meshew
1206 NE 145th St., Shoreline, WA 98155

I, the undersigned, hereby authorize Dr. Meshew to perform the following specific procedures: Acupuncture procedures involving insertion of special needles through the skin, into underlying tissues at specific points on the surface of the body, as well as, other techniques as specifically described of the Washington State Law for certified Acupuncturists such as moxibustion, cupping, etc.

_____I recognize the potential risks and benefits of these procedures as described below:
(initials)
1. Potential risks: Discomfort at the insertion of the needles, infections, pain, bruises, weakness, faintness, nausea, blistering & even aggravation of symptoms existing prior to the acupuncture treatment. MEDICATIONS CAN AFFECT SKIN RESPONSE TO TREATMENT. (Please consult your doctor if you are under any medications.)
I understand the importance of eating prior to treatment to prevent light headedness & fainting.

2. Potential Benefits: Painless and drugless relief of my presenting symptoms & improved balance of energies which may lead to prevention or elimination of the presenting problem.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been made to by Dr. Meshew or any of her personnel regarding cure or improvement of the presenting problem.

I hereby release Optimum Acupuncture & Chiropractic Clinic from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at anytime.

I am fully aware that the clinic allows a specific amount of time for my treatment and if I arrive late my treatment time will be adjusted to fit into that time schedule. I am also aware that, except in emergencies, I must give 24 hours notice of intent to cancel or reschedule an appointment. Late arrivals and appointments missed without proper prior notice will be billed at the current clinic rates.

_____	_____	_____
(Print patient name)	(Patient signature)	(date)
_____	_____	_____
(Print legal guardian/[parent)	(guardian signature)	(date)
_____	_____	_____
(Print witness name)	(witness signature)	(date)