Counterpoint Wellness, PLLC
3417 Evanston Ave. N, #204, Seattle WA 98103 • (206) 395-9796

Patient Treatment Consent, Payment and Cancellation Agreement

Patient's Name:_____

Date of Birth:_____Age:_____

I, the undersigned, hereby consent for Counterpoint Wellness to perform treatment utilizing acupuncture and massage therapy on me (or on the patient named above for whom I am legally responsible).

Nature and Character of the Proposed Treatment
I understand that methods of acupuncture may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, acupressure/tuina (Chinese massage), gua sha (dermal friction technique), Chinese herbal medicine, and dietary advice based on Chinese medical theory. I understand that methods of massage treatment may include, but are not limited to: Craniosacral bodywork (gentle hands-on bodywork focusing on head, spine and pelvis – may include intraoral work), trigger point (holding points of tight tissue to achieve myofascial release), deep tissue (slower and deeper strokes in smaller areas as compared to Swedish techniques), Chinese tui-na (including acupressure, rolling, tapotement, and other techniques to bring the body into balance), and stretching (passive or active movements to lengthen muscular tissue).

Anticipated Results of the Proposed Treatment
I understand that the beneficial effects associated with these treatments include decreased pain, reduced muscle spasm, and improved mobility. I understand there is no certainty that I will achieve these benefits.

I agree to follow the advice given to me by my acupuncturist and massage therapist. I understand I might be dropped from the program for refusal to do so.

Possible Risks of Treatment
I understand that acupuncture and associated treatments are generally safe methods of treatment, but risks may include pain or discomfort during the treatment, fainting/needle sickness, broken needles, bleeding, burning and/or scarring of the skin, infection, organ puncture, bruising (for example, bruising is a common side effect of cupping), pain following treatment in the insertion area, spontaneous miscarriage, pneumothorax, or allergic reactions to ingested herbal medication. I also understand that there are some very slight risks associated with massage, including but not limited to bruising and muscle soreness.

I will notify the acupuncturist at Counterpoint Wellness *prior to treatment* if I have a severe bleeding disorder or pacemaker, or if I am or become pregnant over the course of treatment.

I understand that all needles utilized for the acupuncture treatments are prepackaged, sterile, single-use needles that have never before been used and will be disposed of after each treatment.

Recognized Possible Alternative Forms of Treatment
I understand that reasonable alternatives to the treatments described above include the following:
Medications: I understand that medications can be used to reduce pain.
Surgery: I understand that surgery can reduce pain associated with certain conditions.
Non-treatment: I understand the risks for non-treatment may include increased pain.

Cancellation Fee
I understand that a $50 cancellation fee may be incurred for a cancellation within 24 hrs of my appointment. The full cost will be incurred for any missed appointments.

Consent and Attestation

By signing this document, I am attesting that I have received, read, fully understand and consent to the disclosures, terms, and conditions above, that I have received a copy of my HIPAA and Washington State Notice of Rights and Privacy Practices, have read and fully understand these rights, and have been given the opportunity to ask questions.

By signing this document, I am attesting to my consent to services provided by Samara White, Lac/EAMP, LMT.

Patient Signature:_____Date:_____
(Patient's parent/guardian if Patient under 18)

Clinician: _____Date:_____
Samara White, LAc/EAMP, LMT