ACUPUNCTURE CONSENT FORM

I, _____, voluntarily consent to be treated by Acupuncture administered by, Michael Kowalski, A.P., Dr. Ac., Dipl. Ac. (NCCA).

I understand that Acupuncture is performed by the insertion of special needles through the skin, or in application of heat to the skikn, or both, at certain points on the body with the intent to improve the body functions and/or relieve pain.

I understand that certain side effects may result. These could include localized bruising, some pain or discomfort, weakness, fainting, nausea and the possible temporary aggravation of symptoms existing prior to treatment. This last effect, however, should be considered beneficial and not adverse in that it indicates that the so called "LAW OF CURE" occurring; that suppressed imbalances are being released.

I am aware that the use of Acupuncture is not yet common practice in this community. I accept the fact that no guarantee is made concerning the outcome of my Acupuncture treatments, and I understand that I may stop treatment at any time.

I also consent to the anonymous submission of data relating to my treatments to the Florida State Board of Acupuncture and to all scientific organizations appropriately authorized by the State of Florida. I understand this in no way waives my right to patient confidentiality.

I understand payment is due at the time of appointment. If required, I authorize Acupuncture and Holistic Health Center to bill my insurance company direct for these services. I understand I am financially responsible for charges not covered by my insurance company. I authorize any holder of medical information about me to release any information needed for this and related medicare or medical claims. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits either to myself or to the party who accepts assignment. I am also aware that there will be a $50.00 charge for a missed appointment not cancelled within 24 hours notice.

Signature of Patient or Guardian:_____

Date:_____SSN#_____

Age:_____Date of Birth_____

*A.P. = Acupuncture Physician (Florida). Dr. Ac. = Dr. of Acupuncture (Rhode Island). Dipl. Ac. (NCCA) = Diplomate of the National Commission for the Certification of Acupuncturists.