FULL MOON
ACUPUNCTURE & APOTHECARY

I hereby voluntarily consent to be treated with acupuncture, moxibustion, and/or cupping administered by Martha Rogers, L.Ac., who is licensed in the State of Maryland.

I understand that acupuncture is performed by the insertion of sterile needles through the skin, or by the application of heat to the skin, or by both, at certain points on or near the surface of the body in an attempt to treat body dysfunctions or diseases and to make normal the body's physiological functions. The procedures have been fully explained to me.

I am aware that certain adverse side effects may result. These could include, but are not limited to local bruising, bleeding, fainting, temporary pain and discomfort, and temporary aggravation of symptoms existing prior to acupuncture treatment.

I am aware that if there is a worsening of my ailment or condition or if it does not improve within the time estimated by the acupuncturist, or if a new ailment or condition appears, that I should consult my personal physician or any other licensed physician.

I understand that no guarantees concerning its use and effects are given to me, and that I am free to stop acupuncture treatment at any time.

None of the foregoing provisions preclude the administration to me of conventional medical therapy by a licensed physician when such therapy is deemed appropriate.

I understand that I will be charged for appointments cancelled within less than 24 hours notice of said appointment. I also understand that I must notify the acupuncturist by telephone when I can't make an appointment. _____ Initial

I have carefully read and understand all the foregoing and so am fully aware of what I am signing. I have felt free to ask any questions.

Patient Signature & Date: _____

Email Address: _____ Phone #: _____