Li Zhang, L.AC. , OMD. , M.S.

Treatment Authorization

I, the undersigned, authorize Li Zhang LAC to perform the following procedures:

Acupuncture:
The insertion of sterile, disposable needles through the skin into underlying tissues at specific points on the body.

Cupping:
The application of glass cups to the skin in a manner as to create suction.

Moxabustion:
The burning of an herb on or near an acupuncture point.

Acupressure:
The application of pressure to the acupoints.

Gua Sha:
The rubbing on an area of the body with a blunt instrument.

Bleeding Technique:
The piercing of an acupoint with a sterile lancet in order to release a few drops of blood.

TDP Lamp:
A mineral heat lamp used to warm a large area of the body.

Hot Stone:
Use hot stone place on the body specific area to stimulate the QI flow.

I recognize the potential risks and benefits of the procedures described above.

Potential Risks:

Pain, bruising, bleeding, infection, and/or blistering at the site of the procedure; temporary discoloration of skin and possible aggravation of symptoms existing prior to the acupuncture treatment.

Potential Benefits:

Drugless relief of presenting symptoms and energetic balancing that may lead to prevention, improvement or elimination of presenting problem. With this knowledge I

voluntarily consent to the above procedures, realizing that no guarantees have been made to me by my practitioner regarding cure or improvement of my condition. I release my practitioner from any and all liabilities, 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 this consent and to discontinue participation in these procedures at any time.

_____ _____

Signature of patient or legal guardian Date

Cancellation Policy:

Please give the clinic at least 24 hours notice if you need to cancel or change your appointment.
It is our policy to charge you for missed visits.

Initials of patient/guardian _____

Privacy Policy:

Your personal information is confidential in accordance with the HIPPA patient privacy law. Your information will be shared only with your insurance company and your referring practitioner, unless you give written permission to do otherwise. Correspondence via e-mail is not guaranteed to be secure. If you choose to contact me through e-mail, I will assume you are aware of privacy risks. I have read the above:

Patient signature, Date