

I, _____, hereby authorize EastWest HealthWorks, Inc. to administer Chinese/Japanese Medicine relevant to my diagnosis and treatment, including but not limited to the following:

1. Insertion of various styles and sizes of acupuncture needles into my body at various depths and locations.
2. Heat treatments using *Artemisia Vulgaris* (moxibustion, 'moxa') or a conventional heat lamp. The heat generated from moxa treatments may involve slight discomfort or leave a blister or scar on the skin. With any type of heat, there is always a risk of burn.
3. Cupping may be used to promote circulation of qi (energy) through the meridians. Cups may produce a red/purple color on the area treated lasting for 1-5 days.
4. Electrical stimulation of the needles may be used which produces a vibration or tapping sensation or ion pumping cords may be attached to the needles.

I have been informed that I have the right to refuse any form of treatment. I understand the nature of the treatment and have been informed of the risks and possible consequences involved with this treatment.

I understand that in consideration of the time reserved for me that I may be charged for any cancellation not made at least 24 hours in advance.

Signature _____ Date _____

Printed Name _____

In the case of insurance coverage, I authorize the release of any medical or other information necessary to process my medical claims. I authorize payment of medical benefits to EastWest HealthWorks, Inc. I understand that I am responsible for knowing the benefits and limits of my insurance coverage. I understand, that in the event of third party payments, I shall be personally responsible for any unpaid balance due this office.

Signature _____ Date _____

Printed Name _____