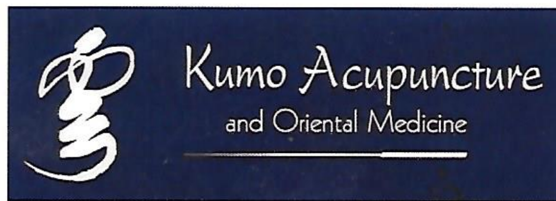

Consent to Treatment

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or other Oriental medical practices by a licensed acupuncturist at Kumo Acupuncture and Oriental Medicine. I understand that acupuncturists practicing in the state of Washington are not primary care providers.

I understand that acupuncture and oriental medical practices will be performed with my consent to treat bodily dysfunction, and that no guarantees concerning their use and effects are given and I am free to stop one or all treatments at any time. Side effect could include but are not limited to:

Acupuncture/Moxibustion: Local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand acupuncture does involve the insertion of needles through the skin, or heat applied to the skin, often in various areas of the body.
Direct Moxibustion: Risk of burning or scarring
Chinese Herbs: Changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call Kumo Acupuncture and Oriental Medicine as soon as possible.*
Acupressure/ Massage: Pain or discomfort, and the possible aggravation of symptoms existing prior to treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Consent to the Use and Disclosure of Health Information – Notice of Privacy Practices

I consent to the use or disclosure of any identifiable health information by Kumo Acupuncture and Oriental Medicine, LLC (hereafter noted as Kumo) for the sole purposes of diagnosis or providing treatment, obtaining payment for my health care bills or to conduct health care operations. I understand that treatment of me by employees of Kumo may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request restrictions as to how my identifiable health information is used or disclosed, and that Kumo is not required to agree to those restrictions. However, if agreed to, Kumo will be bound by those restrictions. Kumo reserves the right to change the information contained in the Notice of Privacy Practices at any time. I may obtain a revised version by accessing the website or requesting the most current notice during an office visit. I have the right to revoke this consent, in writing, at any time except to the extent that my balance is reliant on taking action with information in this consent.

My identifiable health information includes my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Signature: ______________________________ **Date:** ____________________

Printed Name: ______________________________ **Date of Birth:** ______________

---

214 E Birch St, Suite 4 ◊ Walla Walla, WA 99362 ◊ 509.209.9094 ◊ www.kumoacupuncture.com

Appointment Guidelines

In an effort to provide our community with the best possible care, if you are unable to make your scheduled appointment, please call our office within 24 hours prior to your appointment to cancel or reschedule. This will allow us the opportunity to reserve that appointment space for another patient and their healthcare needs.

If you are unable to cancel or reschedule your appointment within the 24 hours prior to your reserved time, we will assess a fee of $60 in an effort to help recoup the costs that occur when we are unable to see patients for a reserved appointment. Thank you for helping us in providing the best possible access to care for all our patients.

Signature:____ Date:____________________