CONSENT FORM FOR ACUPUNCTURE

I, the undersigned hereby authorize Kayo King, L.AC. to perform the following specific procedures:

> Acupuncture procedures involving insertion of special needles through the skin into the underlying tissues at specific points on the surface of the body, as well as other techniques as specifically described in the Washington State Law for Licensed Acupuncturist, such as moxibustion, cupping, and electro-acupuncture.

I recognize the potential risks and benefits of these procedures as described below:

Potential Risks: Discomfort at the site of insertion of the needles, infections, pain, bruising, weakness, fainting, nausea, and even aggravation of symptoms existing prior to the acupuncture treatment.

Potential Benefits: Painless and drugless relief of my presenting symptoms and improved balance of energies, which may lead to prevention, or elimination of the presenting problem.

With this knowledge, I voluntarily consent to the above procedures, realizing that Kayo King, L.AC. has given no guarantees to me, regarding cure or improvement of my condition.

I hereby release Kayo King L.AC. from any and all liability, 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 my consent and discontinue participation in these procedures at any time.

I am fully aware that the clinic allows a specific amount of time for my treatment and that if I arrive late my treatment will be adjusted to fit into that time schedule. **I also understand that, except in emergencies, I must give 24 hours notice of intent to cancel or reschedule my appointment. Late arrivals and appointments missed without proper notice will be billed at the current clinic rate.**

Payment: I am fully aware that my insurance policy is a contract between my insurance company and me, and I agree to accept responsibility for any co-payment and/or deductibles required by my insurance company. I further accept responsibility for any fees or services not covered by my insurance company.

_____ _____

Signature of Patient Date

_____ _____

Signature of Person Authorized to Consent Date