Hugh G. Morison, L. Ac. IN # 84000250A Lic. CA Lic # 7229

INFORMED CONSENT TO ACUPUNCTURE TREATMENT

Patient's name (print) _____

I hereby request and consent to the performance of procedures on me (or on the patient named above, for whom I am legally responsible) which are within the scope of practice of a Licensed Acupuncturist including, but not limited to, acupuncture, acupuncture with electric stimulation, manual and massage therapy, Infrared, dietary supplements and therapeutic exercise by Hugh G. Morison and/or other licensed acupuncturist(s) who now or in the future serve as back-up for Morison, I have had an opportunity to discuss with the acupuncturist named above the nature and purpose of acupuncture. I understand that results are not guaranteed. I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, slight bruising and tingling or soreness near the needling sites that lasts a few days. There have been instances reported of fainting, infections and scarring. There have also been instances reported of spontaneous miscarriage and pneumothorax. I will inform the acupuncturist of any possibility that I might be pregnant or have a cardiac pacemaker. I will give Morison a complete medical history I do not expect the Morison to be able to anticipate and explain all risks and complications, and I wish to rely on him to exercise judgment based upon the facts then known and his professional expertise I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I come to this office to seek treatment.

X_____ /_____/_ _____

Signature of patient or legal guardian Date Printed Name of Patient's Representative

_____ /_____/_____Hugh G. Morison, LAc_____

Provider signature Date

Assignment of Benefit and Release of Information for Insurance Billing

Name of Patient:_____DOB:_____

I, the undersigned, consent to the use of my Protected Health Information for care and payment for care. I permit Hugh Morison, LAc To bill my insurance and assign directly to Hugh Morison, LAc all medical benefit, if any, otherwise payable to me for services and supplies rendered. I understand that Hugh Morison, LAc will share patient protected health information according to the federal and state law for treatment and payment, as well as in accordance with his Notice of Privacy Practices. I hereby authorize Hugh Morison, LAc to release all information necessary to secure payment of benefits to my insurance company. I authorize the use of this signature on all insurance submissions. I acknowledge and understand that I am financially responsible for all charges whether or not they are reimbursed by my insurance company. I acknowledge and understand that all charges remaining after insurance reimbursement will be billed to me._____ (initial here)

Primary Insurance Company:

_____

Patient Member ID #:_____

Subscriber's Name: _____DOB: _____

Relationship to Patient: _____