ALL PRO HEALTH CENTER

5220 Clark Avenue, Suite 445
Lakewood, CA 90712
(562) 867-6183 (562) 866-4740 (FAX)

56 E. Duarte Rd.
Arcadia, CA 91006
(626) 447-4888 (626) 447-4010 (FAX)

INFORMED CONSENT FOR TREATMENT

I hereby authorize the staff of All Pro Health Center and its affiliates to conduct examinations, chiropractic adjustments, acupuncture treatments and other procedures necessary, including but not limited to various modes of physiotherapy, cupping, soft-tissue techniques, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible).

I understand that, as in the practice of medicine, in the practice of chiropractic, there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the staff of All Pro Health Center to be able to anticipate and explain all risks and complications. I wish to rely on the practitioner and/or his staff to exercise judgment during the course of the procedures which he/she feel at the time, based on the fact then known, are in my best interests.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat/smoke to the skin (or both) at certain points near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Cupping/ Tui-Na Massage: I understand that I may also be given cupping/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with acupuncture. I understand that there may be other treatment alternatives, including treatment offered by a licensing physician.

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the All Pro Health Center staff to perform such procedures. I intend this consent from to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.

_____ **Cancellation Policy**: There is a $25.00 fee for any and all appointments that are missed and not cancelled with a 24 hour notice.
(initial)

Payment Policy: I understand that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that All Pro Health Center will prepare any necessary reports and forms to assist me making collections from the insurance. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment for any non-covered services under my health plan. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

_____ _____

Patient Name (Please Print) Date

_____

Patient or Guardian Signature