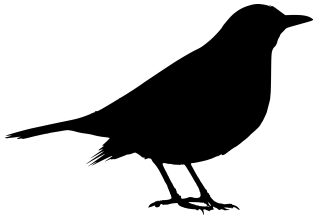


BLACKBIRD
ACUPUNCTURE CLINIC LLC

INFORMED CONSENT

We believe that patients are our partners in their care and wellness. Please ask questions about your treatment so that you may continue to make informed, responsible decisions regarding your health care.

ACUPUNCTURE
I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below for whom I am legally responsible) by any licensed acupuncturist treating me who is currently or will in the future be employed by, working, associated with, or serving as back-up for Blackbird Acupuncture Clinic LLC or any office associated with Blackbird Acupuncture Clinic LLC.

I understand that acupuncture is performed by the insertion of sterile, disposable needles in a clean and safe environment. The procedure may include the application of heat, manual stimulation, or electrical stimulation to certain points/needles on/in the body. Although rare, certain side effects may include but are not limited to: local bruising, minor bleeding, lightheadedness, pain, numbness, tingling, or discomfort, dizziness, fainting, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that I may refuse or stop this treatment at any time.

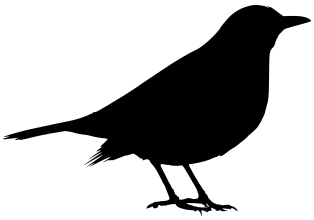
MOXIBUSTION/CUPPING/HEAT LAMPS
I understand that if I receive moxibustion, cupping, or heat lamps (TDP lamps) as part of therapy, there is a risk of burning or scarring from their use. I understand that smoke and unpleasant smells may occur as a result of these therapies. I understand that I may refuse or stop any or all of these therapies at any time.

CHINESE HERBS/NUTRITIONAL COUNSELING
I understand that traditional Chinese herbs, formulas, foods, and supplements may be recommended as part of my treatment. I understand that I am not required to take these substances but if I choose to do so, I must follow the written and/or verbal instructions for preparation, administration, and dosage. I am aware that certain adverse side effects may result from taking these substances including, but not limited to: changes in bowel movement, gas, an unpleasant taste or smell, nausea, vomiting, stomachache, headache, tingling of the mouth, hives or rashes. I understand that herbs may contain plant, animal, and mineral sources and are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses. I understand that some substances may be inappropriate during pregnancy. **Should I experience any problems associated with these herbs, I will immediately suspend taking them and contact Blackbird Acupuncture Clinic LLC as soon as possible.**

ACUPRESSURE/CUPPING/TUI NA/ GUA SHA
I understand that acupressure, Tui-Na massage, gua sha, and cupping may be used as part of my treatment. I am aware that certain side effects may result from these treatments which can include, but are not limited to: sore muscles, aches, bruising, redness, petechia, rashes, or burns. I understand that I may refuse or stop this treatment at any time.

ELECTROACUPUNCTURE/ESTIM/TENS
I understand that electro-acupuncture (estim/tens) may be administered with or without needles during treatment. I am aware that certain side effects may result including, but not limited to: electrical shock, pain, tingling, numbness, or discomfort. I understand that I may refuse or stop this treatment at any time.

ADDITIONAL RISKS
I understand that unusual risks of acupuncture treatments and other procedures within the scope of the practice of acupuncture may occur such as spontaneous miscarriage, nerve damage, organ puncture including lung puncture (pneumothorax), or infection. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time based upon the facts then known, is in my best interest. I will notify a clinical staff member who is caring for me if I am or become pregnant. I understand some minor and major adverse effects may last days to weeks.



INFORMED CONSENT CONTINUATION

CONFIDENTIALITY
I understand the acupuncturist and other clinical and administrative staff may review my patient record and lab reports but all my records will be kept confidential and will not be released without my written consent.

PAYMENTS
I understand that all payments, including co-pays, are due at the time of service and late or forgotten payments including cancellation and no-show fees will not be tolerated. I understand that Blackbird Acupuncture Clinic does not barter services.

CANCELLATION/NO-SHOW POLICY
I understand that if I am unable to keep my appointment, I will give 24 hours' notice. I understand that **if I cancel with less than 24 hours' notice** or do not show for the appointment, **I will be charged a $30.00 fee** which will be my responsibility to pay before my next visit. I understand that if I am 10 minutes late or more to an appointment I may not receive a full treatment or I may not be able to been seen at all. **I understand there may be a $30 fee for late arrivals even if I cannot be treated.**

BY SIGNING BELOW
I voluntarily consent to be treated with acupuncture treatments and/or other procedures within the scope of the practice of acupuncture by a licensed acupuncturist. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop treatment at any time.

I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had the opportunity to ask questions. I understand that the consent form will cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I understand that acupuncturists practicing in the state of WI are not primary care providers and that regular primary care by a licensed physician is strongly recommended.

_____

Patient Signature (or Patient Representative) **Date**

_____

Printed Name (Indicate relationship If signing for patient) **Date of Birth**

_____

Acupuncturist Signature **Date**