Mandy Rose Acupuncture & Herbal Medicine
Informed Consent/Financial/Privacy Policy

By signing below, I do hereby voluntarily consent to be treated with acupuncture and other procedures within the scope of practice by a licensed acupuncturist.

I understand that methods of treatment include acupuncture, moxibustion, cupping, gua sha, acutonics, Chinese herbal medicine, and nutritional counseling. The herbs and supplements (from plant, animal, and mineral sources) are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify the practitioner of any known allergies. I will notify the practitioner of any unanticipated or unpleasant effects associated with the effects of the herbs. **I understand that some herbs may be inappropriate during pregnancy and I will notify the practitioner if I am or become pregnant.**

I understand that acupuncture is performed by the insertion of needles through the skin at certain points in an attempt to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that adverse side effects such as local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment could result. I understand that there are no guarantees of beneficial effects and I am free to stop acupuncture treatment at any time.

I understand that acupuncture is not emergency medicine. If I need urgent care or are experiencing any serious medical issues I acknowledge that there are various services available to me, such as 911, emergency department, and urgent care and I will contact my western medical doctor.

I understand that my records are protected by HIPAA (Health Insurance Portability and Accountability Act of 1996) and will be kept confidential and not be released without my written consent.

I will give AT LEAST 24 hour notice if I need to cancel or change my scheduled appointment, otherwise I will be subject to a late cancellation fee of half my appointment fee. Being more than 15 minutes late to an appointment, not including serious and extenuating circumstances, will result in a cancelled appointment and cancellation fee.

I acknowledge that services may be terminated at the sole discretion of Amanda Rosenberg if she feels that there is not a proper fit, or that my needs or desires are beyond the scope of acupuncture. Two no-shows may result in termination of services.

I acknowledge that fees may increase annually to keep up with the growing costs of providing healthcare in California. Amanda's (Mandy's) preferred method of payment is Cash or Venmo. HSA & FSA credit cards are accepted as well. Payment is due at the time of service. We do not bill directly to insurance but can provide patients with a superbill if needed.

I understand that the preferred mode of communication is email and that it may take up to 24 hours on weekdays, and 48 hours on weekends to receive a response back. Only in the case of an emergency situation, I will phone my practitioner.

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.

Signature: _____ Date: _____

Printed Name: _____

Thanks and enjoy your treatment!
Amanda Rosenberg, L.Ac.