CONSENT FORM

I have come voluntarily for treatment that may include but is not limited to acupuncture, acupressure, electrical stimulation, guasha, cupping, moxibustion (burning of an herb), heat, NAET (allergy elimination), JMT and Reiki (bioenergetic approaches to healing). The procedures involved in this treatment have been explained to me. I understand that I have not been guaranteed any success concerning the uses and effects of treatment, and that I am free to discontinue treatment at any time.

I understand that acupuncture is performed by the insertion of needles through the skin at specifically determined acupuncture points, that NAET is an acronym for Nambudripad's Allergy Elimination Technique, and that JMT is an acronym for Jaffe-Mellor Technique.

I understand that Cheri Suzuki follows universally prescribed precautions to guard against the spread of infection, and that only sterile, prepackaged, disposable, needles are used. Needles that are used for my treatment are used only on me, and are inserted according to clean needle technique based on nationally determined standards.

I understand that certain adverse side effects may result from treatment. These may include but are not limited to slight bleeding, bruising, soreness at site, fainting, temporary pain or discomfort, and temporary aggravation of symptoms existing prior to treatment. Conventional medical therapy may be used in an emergency.

I understand that Cheri Suzuki is an independent practitioner licensed to practice Acupuncture in Maine, that she is not a physician, and that treatment received is not a substitute for Allopathic medical treatment. I know that I am responsible for my own health and the decisions regarding it, and should continue under the care of my physician, and if my condition should become worse, or a new condition arises, I should consult a licensed physician.

I understand that all information in my medical records will remain private and will not be shared with anyone without my written consent, in compliance with HIPPA regulations.

I understand that I will be charged for appointments missed or canceled with less than 24 hours notice except in case of emergency. I understand that I will be charged $25 for any returned checks. I understand that all payments are due at the time of treatment.

I have read and understood all of the foregoing, have asked any questions I have regarding this process and this form, and have had all questions answered to my satisfaction. I am fully aware that by signing this consent form, I am agreeing with its statements.

_____ _____

Signature of patient or responsible party Date

_____

Witness