INNER SPACE ACUPUNCTURE
Dickie Walls, AP
703 Curlew Road
Delray Beach, FL 33444
OFFICE: 561-330-8452

Consent for Treatment

I, _____hereby voluntarily request to receive clinical services from an independent state licensed acupuncture physician at Inner Space Acupuncture by Dickie Walls AP. I understand that these services may include such types of treatment as acupuncture, therapeutic massage, nutritional/dietary counseling, herbal and nutritional therapy, homeopathic consultation, and lifestyle counseling. I acknowledge that no guarantees have been made to the effect of such examinations, treatments, therapy, or care of my condition. I further acknowledge that none of the above services are meant to be construed as the diagnosis or treatment of disease, but are designed to promote and/or restore the flow of vital energy throughout the body that is essential to wellness. I understand that prior to the beginning of any treatment procedure, I will receive an explanation of the nature and purpose of the treatment.

I understand that the possibility of adverse affects as a result of treatment is rare. These affects may include minor bruising from needle insertion (hematoma), or fainting during acupuncture that can be due to being over-hungry, tired or nervous. To prevent the puncture of a vital organ, careful attention will be taken with the insertion of all acupuncture needles in the areas of important viscera (chest, ribs, abdomen, and back). I understand that when nutritional, herbal or homeopathic formulations are recommended, it is important to follow the guidelines set forth by my practitioner. I further understand that every effort to prevent herb-drug interactions is taken. Reactions to these formulations are rare, but can take place. If a reaction occurs, I agree to inform my practitioner, immediately, for further instructions.

I agree to be in communication with my practitioner if I have any questions regarding my treatment. I understand that I may refuse any and all services at any time. Finally, I understand that all clinical information will be kept strictly confidential as governed by state and federal regulations.

Signature of Client_____ ***Date*** _____