***Jason Blalack*, MS, Dipl.Ac., L.Ac.**
Open Gate Acupuncture
745 Poplar Ave.
Boulder, Colorado 80304
phone: 720-675-7297

Consent Form

I hereby request and consent to receive acupuncture treatment from Jason Blalack, Dipl.Ac., L.Ac. I understand that methods of treatment may include, but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, tui na, herbal medicine, and nutritional and lifestyle counseling.

I have had an opportunity to discuss questions I have regarding the nature and purpose of acupuncture and Oriental medicine along with the potential risks of treatment. I also realize that as questions arise, I may feel free to ask them. I understand that although acupuncture and Oriental Medicine has benefited millions of people, over thousands of years, no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that although acupuncture is a safe method of treatment, there are some risks to treatment, area of anesthesia, fainting, dizziness, nausea, bruising, infection, burns, pain and discomfort, pneumothorax, and aggravation of present symptoms. I am fully aware that the acupuncture needles are sterile and disposable and that no needle used ever been used on another person.

I understand that Oriental Medicine is not a substitute for standard Western Medicine, and I may seek Western medical advice and treatment at any time either instead of or concurrently with acupuncture treatment.

I have read, or have had read to me, the above consent to treatment. I have also had an opportunity to ask questions about its content. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for I seek treatment.

________________________________ ________________
Signature *Date*

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Printed Name

Parent or Guardian Signature
I, the parent or guardian of the above named minor, hereby consent to all the above terms and conditions implied in the above document. I give permission for my minor child to undergo acupuncture treatments.

________________________________ ________________
Parent / Guardian Signature *Date*