JI SUNG KIM ACUPUNCTURE, P.C.

INFORMED CONSENT/ADVICE TO CONSULT A PHYSICIAN

1. I have been informed to consult, or have been referred by a medical doctor for the condition I am seeking acupuncture. "Acupuncture" means the stimulation of a certain point or points on or near the surface of the body by the insertion of special needles to prevent or modify the perception of pain or to normalize physiological functions, including pain control, for the treatment of certain diseases or dysfunctions of the body, and includes the techniques of electro-acupuncture, mechanical stimulation and moxibustion. The potential risks are: slight pain or discomfort at the site of needle insertion, infection, bruises, weakness, fainting, nausea and even aggravation of symptoms existing prior to acupuncture treatment. The potential benefits: acupuncture may allow for painless and drugless relief of one's symptoms and improved balance of bodily energies leading to prevention or elimination of the presenting problem. With this knowledge I voluntarily consent to the above procedures.

Signature of patient/guardian **X**_____

Ji Sung Kim Acupuncture, P.C. License #003161_____

AUTHORIZATON TO RELEASE INFORMATION.

2. I authorize the release of any medical or other information necessary to process this claim. Such information may include but is not limited to medical records, independent medical examinations, and SIU reports. I also request payment of government benefits either to myself or to the party who accepts assignment.

Signed **X**_____

HIPPA PRIVACY NOTICE

3. I have read the provider's HIPPA Healthcare Privacy Practices notice.

Signed **X**_____

AUTHORIZATION FOR A MINOR

4. I am the legal guardian of_____. I hereby authorize **Ji Sung Kim Acupuncture, P.C.** and his designates to treat this minor child with acupuncture, and am the authorized person to sign for this minor child.

Signed_____Relationship_____