MY METRO MEDICINE

Consent to Services

Effective November 24, 2019

I have read and understand all parts of this form and acknowledge that the purpose, goals, techniques, procedures, limitations, and potential risks and benefits of the service(s) to be performed have been explained to me. I have also received and reviewed the Notice of Privacy Practices and the accompanying Practices Regarding Disclosure of Client Health Information. I understand my health information will be used and disclosed consistent with this Notice, and that I have the right to request restrictions on certain uses and disclosures of my health information. Furthermore, I have had and taken the opportunity to ask my practitioner questions regarding the proposed services, this consent form, and other pertinent information necessary for me to make my final consent for services provided to me by the practitioners of My Metro Medicine. In addition, I understand that I am free to discontinue service(s) at any time.

Acupuncture & Chinese Medical Therapy

Services to be provided

I understand that acupuncture and additional Chinese medical therapies including, but not limited to, cupping, moxibustion, gua sha, acupressure, qigong, blood-letting, shonishin, tui na, electroacupuncture, and Chinese herbal consultations serve individuals with a wide range of complaints including both acute and chronic healthcare issues. I understand that I may be treated with the insertion of needles and/or with the application of heat, cupping, or other Chinese medicinal substances, techniques, or devices used on, in, or above the skin depending on the practitioners treatment design and diagnosis. I also understand that I may be requested to expose areas of the body required and/or related to the treatment provided during the specific appointment, and I have the right to decline such requests from the licensed practitioner providing such service(s).

Risks/Possible Side Effects

I understand that acupuncture and additional Chinese medical therapies provided may result in certain side effects, including local bruising, slight bleeding, fainting, temporary pain and discomfort, and temporary aggravation of symptoms existing prior to treatment.

Movement Therapy & Physical Training

Services to be provided

I understand that movement therapy and physical training consists of services including but not limited to Exercise and Rehab, Tai Chi, Qigong, Martial Arts, Self-Defense, Postural Assessment, and any related service provided henceforth. I understand these services may require physical manipulation by the instructor or practitioner for instructional or diagnostic purposes, and I have the right to decline such manipulation from the above mentioned instructor or practitioner.

Risks/Possible Side Effects

I understand that it is my responsibility to report to my instructor or practitioner any discomfort or pain experienced during my time at or with My Metro Medicine and its instructors or practitioners. I agree that I will not hold any instructor or practitioner of My Metro Medicine responsible for any discomfort or adverse effect I may experience during my time at, with, or in conversation with My Metro Medicine and its instructor or practitioners.

Health and Life Coaching

Services to be provided

I understand that health and life coaching is a service involving interviews and questionnaires conducted by a My Metro Medicine practitioner and that services may also include brief instruction on physical training and/or movement therapies deemed necessary or potentially beneficial to me by said provider of My Metro Medicine. I understand all information gathered for the purpose of my health and life coaching session will be held strictly confidential, and I understand that I may decline to answer any questions brought forward by any instructor or practitioner of My Metro Medicine.

Risks/Possible Side Effects

I understand that any actions or lifestyle changes made in my personal life are done so by my own doing and my individual consent. I will not hold any practitioner or instructor of My Metro Medicine responsible for any reaction I may experience upon completion of my time at, with, or in conversation with My Metro Medicine and its instructors or practitioners.

Information Disclosures

No Guarantees

I understand that each person is unique as a human being and has ultimate responsibility for his or her own healthcare. I acknowledge that I have not received any guarantees or promises as to the results or success that may be obtained from the services provided by a My Metro Medicine instructor or practitioner.

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Infectious Disease Prevention

I understand that infectious diseases are carried through the air, through physical contact, and through bodily fluids. I understand that My Metro Medicine follows universally prescribed precautions and procedures (such as clean needle technique, hand washing, and cleaning of equipment used for clinical purposes and services) to prevent the spread of infectious diseases. Furthermore, I understand it is my responsibility to maintain good hygiene and practices for disease prevention, including but not limited to hand washing, in order to preserve a state of good health for myself and those around me. As My Metro Medicine may use certain cleaning supplies or products to maintain a disease preventive environment for all clientele, I will not hold any instructor or practitioner of My Metro Medicine responsible for any reaction I may have related to direct or indirect contact of any cleaning supply or product used by My Metro Medicine, and it is my responsibility to inform my instructor or practitioner of any possibility or vulnerability I may have to said cleaning supplies or products.

Client Responsibilities

I understand that it is my responsibility as a client to inform my practitioner of all aspects of my health and that, as service progresses, to inform my practitioner of changes that occur. I will inform my practitioner if I am pregnant and/or suspect pregnancy at any time. If I experience any pain, discomfort, or possible adverse side effects, it is my responsibility to immediately notify my instructor or practitioner.

Medical Treatment

I understand that My Metro Medicine instructors and practitioner are not substitutes for medical doctors and will not suggest that I discontinue medical treatment or any prescriptions I have been prescribed by any provider outside of My Metro Medicine. I understand that if I am currently under a physician's care, I should continue as long as my physician deems necessary. It is my responsibility to consult with my physician before altering any medications or medical treatments. I understand that My Metro Medicine may request a physical exam if it has been over a year since my last examination. I am free to consult a medical doctor or any other licensed practitioner at any time. I understand also that if there is an emergency, or a worsening of my health condition, or if a new ailment or condition arises, that I should consult a licensed physician.

Fees, Charges, and Insurance

I understand that all fees are required to be paid at the time of service and in accordance with the Fee Schedule provided by My Metro Medicine. I also understand that all fees are subject to change at any point at the discretion of My Metro Medicine and any discrepancy related to any fees should be brought to the attention of Justin Flinner, Owner of My Metro Medicine, before I commit to service or engage in any transaction. I also understand that My Metro Medicine does not accept insurance nor does My Metro Medicine file directly with any insurance company for any kind of reimbursement. I understand it is my responsibility to contact my insurance provider prior to any appointment with My Metro Medicine regarding the possibility of reimbursement. Furthermore, I will not hold any instructor, practitioner, or administrator of My Metro Medicine responsible for any financial related issues, i.e. reimbursement, that may arise due to any insurance filing on my part. I also understand that if I need to cancel my appointment with My Metro Medicine I must cancel at least 24 hours in advance, or I will be responsible for the full fee of the scheduled appointment. Finally, I understand that a $35.00 fee will be assessed for any check that is returned by my bank for non-payment.

I, the undersigned, hereby acknowledge receipt of, fully understand, and agree to abide by the two-page *Consent to Services* laid out above. If I am under 18 years of age, I am required to have a parent or guardian sign on my behalf.

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Printed Name of Client, Parent, and/or Guardian

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Signature of Client, Parent, and/or Guardian

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Date