WEI LI ACUPUNCTURE, INC

10303 NE Weidler St, Portland, OR 97220 • 846 Commercial St SE, Salem, OR 97302 • 12575 SW Main St, Tigard, OR 97223
(503) 254-8218

Online Consent Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental material medica by Wei Li Acupuncture, Inc. I understand that acupuncturists practicing in the state of Oregon are not primary care providers and that regular primary care by a licensed physician is strongly recommended by Wei Li Acupuncture, Inc.

I understand that Wei Li Acupuncture, Inc., requests that all patients have a primary care provider as part of a comprehensive care program and that all patients provide medical records from this provider upon request. I understand that data from this clinic may be used for teaching purposes; however, in all cases all information will be anonymous and held in strictest confidence. All staff is held to strict confidentiality requirements.

Chinese Herbs: I understand that the substances from the Oriental material medica may be recommended to me to treat bodily dysfunction or disease or to modify or prevent pain perception and to normalize the body's physiological functions. I understand that I am not required to take these substances but that I must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems that I associate with these substances, I should suspend asking for them and call* Wei Li Acupuncture, Inc. *as soon as possible*.

Payment: I understand that I will receive an invoice for each online consultation, and that payment is expected within one week of my online consultation. I understand that Wei Li Acupuncture, Inc., does not bill insurance, but that billing receipts are provided to me for reimbursement for services covered by my insurance.

Alternatives: I understand that there may be other treatment alternatives, including treatment that might be offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I give my permission and consent to treatment.

Signature: _____ Date: _____

Name (*Printed*): _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone (*Home*): _____ Phone (*Mobile*): _____

Email Address: _____