

**Stuart S. Shipe, D.O.M., P.A.**

**CONSENT**

I hereby consent to the following provisions deemed clinically necessary by Stuart S. Shipe, D.O.M., P.A.

Patient's Name \_\_\_\_\_  
( Please Print )

A. **TREATMENT** – Any and all health care and treatment that may include Acupuncture, herbal formulas, Tui-Na oriental body work, cupping therapy, moxibustion, therapeutic exercises, aricular therapy, pharmaceutical and/or nutritional counseling. I understand that needling and cupping therapy may cause bruising in some cases. Moxibustion may produce blisters in some cases.

B. **AUTHORIZATION OF COMPENSATION** – Payment is made directly to Stuart S. Shipe, D.O.M., P.A. for the amount due at the time of service. Payment can be made by the following:

*Please Check One:* CASH \_\_\_ CHECK \_\_\_ DEBIT \_\_\_ OR  
CREDIT CARD: MASTERCARD \_\_\_ DISC \_\_\_ AMEX \_\_\_ VISA \_\_\_

I have read, understood, and agreed to the information, waivers and representations stated above.

A photocopy of this form shall be considered as effective as the original.

\_\_\_\_\_  
Patient's Signature (Parent/Guardian if minor) Date \_\_\_\_\_