Terra Wellness

1247 7th Street, Suite 300, Santa Monica, CA 90401
terrawellness@gmail.com 310-985-6700

PERMISSION & AUTHORIZATION FORM

I specifically authorize Terra Gold a practitioner of Terra Wellness to perform consultations which may include physical assessments, an applied nutrition testing health analysis and/or acupuncture to develop a natural, complementary health improvement program for me which may include therapeutic exercises, dietary guidelines, nutritional supplements, acupuncture etc. in order to assist me in improving my health, **and not for the treatment, or "cure" of any disease.**

No promise or guarantee has been made regarding the results of yoga therapy, acupuncture, nutritional supplements or any natural health recommendations. Rather, I understand that the Terra Wellness programs are a means by which the body's natural reflexes can be used as an aid to determining possible imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

In the case of acupuncture treatments:

I understand that the administration of acupuncture could directly or indirectly result in minor adverse effects to my body including, but not restricted to, lightheadedness, minor bleeding, bruising, soreness, pain, and general relaxation.

I further acknowledge that I am not seeking or undergoing acupuncture as a result of any inducement or representation or promises made by the acupuncturist or any other person in the office. I wish to proceed freely and voluntarily with such treatment and authorize Terra Gold, L.Ac. to proceed with such treatment with the full and informed consent on my part of all the relevant facts as set forth in this consent form. This consent shall apply to my initial and all subsequent acupuncture treatments.

I have read and understand the foregoing.

This permission form applies to subsequent visits and consultations.

Date: ______________________

Print Name: ____

Signed: ____

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SERVICES POLICY

Payment of services are made at the time of treatment. If your insurance covers acupuncture I will bill them for you. Fees for treatment do not include the cost of herbs or supplements. Having insurance is not a substitute for payment. Many companies have fixed allowances or reimburse based on a percentage that is pre-determined on your contract with them. It is the patient's responsibility to pay the deductible, co-payment, and any other balances not paid by your insurance.

CANCELLATION POLICY

A 24-hour cancellation notice is required prior to your appointment time. If sufficient time is not given, the full fee will be charged.

I have read and understand the foregoing.

Date: ______________________

Print Name: ____

Signed: ____