Dear Patient:

We need your assistance with our appointment schedule. Although it is possible that missing a doctor's appointment is just an oversight or perhaps there was a more urgent reason. If given enough time, we can accommodate other patients in need. The following statement is our Financial and Cancellation Policy, which we require you to read and sign prior to any treatment.

Insurance is billed as a courtesy to our patients; however, the patient is the final responsible party. This policy reduces your out-of-pocket expenses and allows you to place your family under care. We do not accept assignment for secondary insurance carriers, but will be happy to provide you with a claim for your secondary carrier. If your insurance has not paid in 60 days, you (the patient) will be notified, and will need to take an active part in recovery of your claim. If your insurance carrier has not paid in 90 days, you (the patient) will be responsible for payment in full for any outstanding balance and you authorize us to use your credit card to collect full payment.

As a courtesy, we text to remind our patients of their appointments the day before your appointment. We are asking that you give us 24 hours notice before your scheduled appointments to cancel or reschedule. As a courtesy to our patients, there is no charge for the first missed appointment. But after that, a service charge will apply. Please refer below:

- 1st No show or late cancel/reschedule- No Charge
- Cancel/Reschedule at least **24hours before appointment**- No Charge
- Late Cancel/Reschedule/15mins late- $50 or treatment in membership/package

You must text our office at 407.370.4444 or email info@acupuncturefit.com to reschedule your appointment.

Thank you for your cooperation.

FULL PAYMENT, CO-PAYMENT, PERCENTAGES, AND/OR DEDUCTABLE ARE DUE AT THE TIME SERVICES ARE RENDERED, OR BY AN AUTHORIZED MEMBERSHIP PLAN/ PACKAGE. ALL SALES ARE FINAL. NO REFUNDS. WE ACCEPT CASH, CHECKS, APPROVED GIFT CARDS, VOUCHERS, AND MOST MAJOR CREDIT CARDS.

As of today's date, I acknowledge that I have read the above and understand this policy.

_____ _____

Print Name Date

_____

Signature

ACUPUNCTURE FIT
PATIENT DEMOGRAPHICS

Last Name:_____ First Name:_____ MI:_____

Social Security # _____-_____-_____ Marital Status:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Email:_____ Cell Phone:_____

Employment Information

Employment Status:_____ Professional Title:_____

Employer Name:_____ Employer Phone:_____

Employer Address:_____

City:_____ State:_____ Zip Code:_____

Emergency Contact

Last Name:_____ First Name:_____ Relationship:_____

If information is different from above please complete the following:

Emergency Address:_____

City:_____ State:_____ Zip Code:_____

Cell Phone:_____

Next of Kin

Last Name:_____ First Name:_____ Cell Phone:_____

How did you hear about us?

_____

By signing below I authorize release of all information and records, including diagnostic reports, consulting reports, and imaging concerning my healthcare and treatment. It is my responsibility to notify Acupuncture Fit if any of this information should change. Please inform reception of any changes to update your records.

_____ _____ _____

Print Patient Name (or Patient Representative Name with Relationship to patient) | Relationship | Todays Date

_____

Patient Signature (or Patient Representative Signature)

ACUPUNCTURE FIT
PATIENT INTAKE FORM

Last Name: _____ First Name: _____ DOB: _____ Gender: ☐ Male ☐ Female

Select all that apply:
☐ Pregnant
☐ Pacemaker
☐ HIV Disease
☐ Hepatitis
☐ Blood Transfusion

Currently Under Care of:
☐ MD
☐ Chiropractor
☐ Therapist
☐ Massage Therapist
☐ Acupuncture Physician

Chief Complaints in order of importance:

(Main health concerns, how/when did they begin)

1. _____

2. _____ 3. _____

4. _____ 5. _____

History of Present Illness (Please check all that apply within last 3 months)

General: ☐ Weight Changes ☐ Fever ☐ Chills ☐ Trouble Falling Asleep ☐ Trouble Staying Asleep _____

HEENT: ☐ Headaches ☐ Vision Issues ☐ Hearing Issues ☐ Nose Bleed ☐ Runny Nose ☐ Throat/Voice Issues

Head:
- ☐ dizziness
- ☐ migraine

Headaches:
- ☐ front ☐ side
- ☐ top ☐ back
- ☐ head injury
- ☐ facial pain
- ☐ facial paralysis
- ☐ sinus problems
- ☐ heaviness in head

R L Eyes:
- ☐ ☐ cataracts/glaucoma
- ☐ ☐ eye pain
- ☐ ☐ twitching
- ☐ ☐ floaters/spots
- ☐ ☐ poor vision
- ☐ ☐ blurry vision
- ☐ ☐ night blindness
- ☐ ☐ itchiness
- ☐ ☐ glasses/contacts
- ☐ ☐ red eyes

R L Ears:
- ☐ ☐ loss/poor hearing
- ☐ ☐ discharge
- ☐ ☐ earaches
- ☐ ☐ itchiness
- ☐ ☐ inflammation
- ☐ ☐ tenderness

Ringing in ears:
- ☐ ☐ loud
- ☐ ☐ soft
- ☐ ☐ high pitch
- ☐ ☐ low pitch

Nose:
- ☐ loss of smell
- ☐ good sense of smell
- ☐ allergies
- ☐ nasal discharge

Color:
- ☐ white ☐ clear
- ☐ green ☐ yellow

Amount:
- ☐ mod ☐ heavy
- ☐ thick ☐ thin

Mouth:
- ☐ grind teeth
- ☐ drooling
- ☐ excess saliva
- ☐ dry mouth
- ☐ dry lips
- ☐ gum disease
- ☐ bad breath
- ☐ scanty
- ☐ sores

Throat:
- ☐ dry throat
- ☐ hoarseness
- ☐ sore throat
- ☐ loss of voice
- ☐ difficulty swallowing
- ☐ 'lump in throat'
- ☐ tonsilitis

_____ **# Of Bowel Movements:**
- ☐ per day
- ☐ week
- ☐ month

Other: _____

Respiratory: ☐ Cough ☐ Shortness of Breath ☐ Coughing up Blood ☐ Blood in Mucus

- ☐ pneumonia
- ☐ bronchitis
- ☐ asthma
- ☐ coughing blood
- ☐ wheezing
- ☐ freq. colds

Cough:
- ☐ dry ☐ croup
- ☐ rapid ☐ chronic

Phlegm:
- ☐ thin ☐ thick
- ☐ clear ☐ white
- ☐ yellow ☐ green

- ☐ tightness in chest
- ☐ sinus infection
- ☐ sinus congestion
- ☐ post nasal drip
- ☐ heaviness/fullness in chest

Difficulty Breathing:
- ☐ sitting ☐ lying down
- ☐ difficulty inhaling
- ☐ difficulty exhaling
- ☐ freq. sighing
- ☐ other chest discomfort

Other: _____

Cardiovascular: ☐ Chest Pain ☐ Palpitations ☐ Swelling of legs or feet

- ☐ high blood pressure
- ☐ low blood pressure
- ☐ fainting
- ☐ cold hands/feet
- ☐ irregular heartbeat
- ☐ insomnia
- ☐ dream disturbance
- ☐ coma
- ☐ loss of consciousness
- ☐ heart pounding
- ☐ stifling sensation in chest

Other: _____

History of Present Illness Continued (Please check all that apply within last 3 months)

Abdominal: ☐Nausea ☐Vomiting ☐Constipation ☐Diarrhea ☐Abdominal Pain ☐Blood in Stool

☐cramping
☐gas after meals
☐stomach pain
☐overeat
☐tastelessness
☐fatigue after eating

☐belching
☐hiccup
☐heart burn/reflux
☐bulimia
☐"nervous stomach"
☐cravings

Stools:
☐loose ☐bloody/black
☐difficult ☐mucous
☐dry/hard ☐painful

Appetite:
☐increased ☐poor
☐no desire to eat

☐hemorrhoids
hernia
☐flatulation
☐gall stones

Rectal:
☐ pain ☐bleeding

Abdomen:
☐tenderness
☐fullness
☐burning

Other:_____

Musculoskeletal:

☐swelling
☐burning
☐weakness
☐numbness

☐tingling
☐arthritis
☐clicking
☐stiffness

☐spasms
☐twitching
☐tremors/shaking
☐soreness

☐tenderness
☐unsteadiness
☐tension
☐heaviness

(rate pain on scale of 1-10, 10=worst)

Area:

R	L		
☐	☐	face	0
☐	☐	jaw	0
☐	☐	chest	0
☐	☐	epigastric	0
☐	☐	rib cage	0
☐	☐	abdominal	0

R	L		
☐	☐	pelvic	0
☐	☐	groin	0
☐	☐	neck	0
☐	☐	shoulder	0
☐	☐	finger	0
☐	☐	sacrum	0

R	L		
☐	☐	upper back	0
☐	☐	mid back	0
☐	☐	lower back	0
☐	☐	sciatica	0
☐	☐	arm	0
☐	☐	knee	0

R	L		
☐	☐	leg	0
☐	☐	foot	0
☐	☐	whole body	0
☐	☐	other bone	0
☐	☐	other muscle	0
☐	☐	other joint	0

Pain is present:
☐ daily
☐ monthly
☐ weekly
☐ quarterly
☐ annually

Carry Heavy objects:
☐often
☐not often

Is/does pain:
☐fixed ☐moves around
☐radiates ☐sharp ☐dull

Pain is ***Aggravated by:***
☐sitting
☐standing
☐movement
☐pressure
☐warmth
☐weather

Pain is ***Alleviated by:***
☐sitting
☐standing
☐movement
☐pressure
☐warmth
☐weather

Other:_____

Skin: ☐Skin changes ☐Rashes ☐Masses

☐psoriasis
☐eczema
☐hives
☐discharge

☐odd skin texture
☐itching
☐fungus/yeast
☐dry skin

☐moist skin
☐pimples/acne
☐bruises
☐herpes

Hair:
☐thinning ☐balding
☐loss of body hair ☐change in hair
☐dandruff

Other:_____

Genito-urinary:

Urine:
☐burning ☐painful
☐scanty ☐dribbling

Color:
☐ cloudy ☐pale
☐ dark yellow ☐pink/red

☐unable to hold urine
☐unable to urinate
☐urgency to urinate
☐wakes up to urinate more than once
How many times? N/A

☐sexually active
☐impotency
Sex drive
☐increased ☐diminished
☐genital itching
☐genital sores/pain

☐discharge
history of:
☐kidney stones
☐bladder infections
☐prostate problems
☐STD

Other:_____

Men's Health:

☐infertility
☐swellings/lumps and pain in testicles
☐cold feeling in genitals
☐difficult ejaculation

☐painful erections
☐discharge from penis
☐difficult achieving/maintaining erection
☐injury to reproductive organs

Other:_____

History of Present Illness Continued (Please check all that apply within last 3 months)

Neurological: ☐ Loss of any sensation ☐ Loss of Bowel or Bladder function ☐ Tremor

☐ shaking ☐ tics ☐ coma ☐ concussion ☐ paralysis ☐ trauma at birth ☐ seizures

Delivered:
☐ vaginally
☐ C-section

Other:_____

Psychological: ☐ Suicidal Ideation ☐ Homicidal Ideation ☐ History of Mental Illness

Please also indicate if you have been diagnosed with any of the following:

☐ depression	☐ moody	☐ sadness	☐ easy to anger	☐ extrovert	☐ ADD
☐ anxiety	☐ fear/fright	☐ frustration	☐ irritability	☐ introvert	☐ ADHD
☐ easily stressed	☐ phobia	☐ melancholy	☐ restlessness	☐ poor memory	
☐ confusion/foggy	☐ hyper	☐ grieving	☐ freq. sighing	☐ panic	
☐ unable to focus	☐ joyful	☐ emotional	☐ over-worried	☐ feeling stuck	
☐ lack of clarity	☐ giddy	☐ hopelessness	☐ over-thinking	☐ attempted suicide	

Other:_____

Infertility:

How long have you been trying to get pregnant?_____

Have you tried any method of assisted reproduction?_____

Any long term exposure to chemicals?_____

Do you keep BBT (Basal Body Temperature)?_____

Do you test yourself for ovulation?_____

Has your partner been evaluated for infertility?_____

Other:_____

Gynecology:

Date of last PAP: _____

Age at Menopause:_____

Last Menstrual Period:_____

Length of period:_____

Days of Heavy Flow:_____

Select the number of:
Pregnancies: 0
Live Births: 0
Miscarriages: 0
Abortions: 0
Premature Births: 0

Period Blood Color:
☐ pale red ☐ light red
☐ red ☐ dark red
☐ red/purple ☐ purple
☐ dark purple ☐ brown

Clots:
☐ large ☐ small

Menstrual Pain/Cramps:
☐ before ☐ during
☐ after
☐ body change before period
☐ mood change before period
☐ spotting between periods

Period Blood Flow:
☐ thick ☐ thin

Vaginal Discharge:
☐ odor ☐ no odor
☐ watery ☐ thick
☐ curdy ☐ itchy

Discharge color:
☐ clear ☐ white
☐ yellow ☐ bloody

Amount:
☐ scanty ☐ mod
☐ heavy ☐ very heavy

Birth Control Pills:
Type:_____
How long:_____

☐ endometriosis
☐ vaginal burning/itching
☐ pain during intercourse
☐ uterine prolapsed
☐ vaginal pain
☐ fibroids
☐ keeps track of cycle
☐ late cycle (less than 35 days)
☐ early cycle (less than 21 days)
☐ irregular cycle
☐ genital eruptions
☐ hormone replacement
☐ decreased libido
☐ absent menstruation

Other:_____

Breast:

☐ history of breast disease
☐ breast lumps/masses
☐ history of breast cancer
☐ breast tenderness
☐ breast fullness/swelling
☐ breast pain

Breast Discharge: ☐ clear ☐ white ☐ yellow ☐ green ☐ black ☐ black ☐ blood ☐ watery ☐ thin ☐ thick

Other:_____

Energy Level:
☐ high
☐ moderate
☐ low

Thirst Desires:
☐ hot
☐ cold
☐ room temp

Cold	Hot	Sensations
☐	☐	hands
☐	☐	feet
☐	☐	back
☐	☐	solar plexus
☐	☐	abdomen
☐	☐	whole body

Intolerance to:
☐ cold ☐ hot ☐ wind
☐ fan ☐ A/C

Work Odd Hours:
☐ Yes ☐ No

Are you taking:
☐ Aspirin
☐ Blood Thinners

Do you make time for meditation and prayer?
☐ yes ☐ no

Do you follow special diet?
☐ yes ☐ no

If yes, what type?_____

Your Past Medical History/Illness:

☐ addiction	☐ cancer	☐ gall stones	☐ liver disease	☐ rheumatic fever
☐ AIDS/HIV	☐ candida (yeast)	☐ glaucoma	☐ low blood pressure	☐ seizues
☐ alcoholism	☐ chemical dependency	☐ gout	☐ mental illness	☐ STD
☐ allergies	☐ chronic fatigue syndrome	☐ headaches	☐ migraine	☐ stroke
☐ anemia	☐ chronic lung disease	☐ heart disease	☐ mononucleosis	☐ suicide attempt
☐ arthritis	☐ colitis	☐ hepatitis	☐ multiple sclerosis	☐ thyroid disease
☐ asthma	☐ cough (whooping)	☐ hernia	☐ organ transplant	☐ tuberculosis
☐ auto immune disease	☐ diabetes	☐ herniated disc	☐ osteoporosis	☐ ulcers
☐ bi polar disorder	☐ eating disorder	☐ high blood pressure	☐ Parkinson's	☐ vaccine reaction
☐ bleeding disease	☐ epilepsy	☐ high cholesterol	☐ pnemonia	
☐ bronchitis	☐ fracture	☐ kidney disease	☐ prostate issues	

Other:_____

_____

Surgical/Traumatic History:

(Please include car accidents, falls, complications, etc and dates)

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Family History:

☐ abuse	☐ allergies	☐ chemical dependency	☐ high blood pressure	☐ stroke
☐ AIDS	☐ asthma	☐ diabetes	☐ mental illness	☐ seizure
☐ alcoholism	☐ cancer	☐ heart disease	☐ diseases	

Habits/Excessive Usage:

(please indicate how much/often)

alcohol:_____ exercise:_____

artificial sweetener:_____ food:_____

chocolate:_____ sex:_____

cigarettes:_____ tea:_____

coffee:_____ salt:_____

soda:_____ sugar:_____

drugs:_____ water:_____

Smoking: ☐ smoker ☐ former smoker ☐ never smoked frequency:_____

Smoking Comments:_____

Allergies:

Drugs/Medication:_____

_____

Chemicals:_____

Food:_____

Seasonal/Environmental:_____

Current Medications, Occupational/Environmental Exposures:

Medications:_____

_____

Chemical:_____ Electrical:_____

Acid/Alkaline:_____ Physical Labor:_____

Heavy Metals:_____ Psychological:_____

Height:_____ Weight:_____ Blood Pressure:_____ Temperature:_____

INFORMED CONSENT TO ACUPUNCTURE CARE

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tiu-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side *effect* of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping.

I understand that while this document describes the major risks of treatment, other side *effects* and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Print Patient Name (or Patient Representative Name and Relationship to Patient) Date

_____

Patient (or Patient Representative) Signature

Office only: Received by _____

Signature _____

Insurance: Assignment of Benefits and Direction to Pay Benefits Owed to Acupuncture Fit, Inc 4700 Millenia Blvd. Suite 175 Orlando, FL 32839

I, the undersigned insured or beneficiary of an insurance policy, irrevocably assign to Acupuncture Fit, Inc. on file with the Div. of Corporations, hereafter "Provider" whatever rights I have under any policy of insurance and under Florida law, including, without limitation, any and all claims for attorney's fees, costs, interest and/or damages pursuant to Florida Statute 624.155. This Assignment of Benefits (AOB) includes an assignment of any potential claim for common law or statutory bad faith. If the Insurer disputes the validity of this AOB, then the insurer is instructed to notify the provider in writing within 10 days of receipt of this document. Failure to do so shall result in the provider relying on this AOB for direct payment and could constitute a waiver by the insurer to contest the validity of this document. I do hereby confirm that this AOB is irrevocable and instruct any insurance company or other collateral source for which I am entitled to benefits to pay for monies owed as a result of medical services rendered by (Provider) to promptly make payment in the name of and directly to (Provider) or its chosen billing service.

Pursuant to this AOB, (Provider) is authorized to file suit on my behalf against any insurance company that reduces or denies benefits for medical services rendered to me and to collect any damages awarded or settlement monies for services rendered, plus interest, costs, reasonable attorney's fees and a contingency fee multiplier. I understand that in any such lawsuit, my name or other identifying information will need to be included in and/or portions of my medical file attached to pleadings and/or formal discovery. I waive any confidentiality of my records and/or information but only to the extent necessary to prosecute a claim for unpaid or owed medical expenses against the insurance company or any other responsible party.

I acknowledge that (Provider) objects to any reductions or partial payments by the Insurer. Any partial or reduced payment, regardless of the accompanying language, issued by the Insurer and deposited by (Provider) shall be done under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. (Provider) reserves the right to seek the full amount of the bill submitted from the insurance company(ies) or me. Accordingly, the insurer is hereby instructed to set aside (escrow) any and all reduced or denied benefit payments for medical services rendered by this provider and not pay the disputed amount to anyone until the dispute is resolved.

I further instruct my insurance company to cooperate with the above-captioned (Provider) in resolving all medical billing disputes. Cooperation includes, but is not limited to, providing any and all declaration pages, PIP logs, payout ledgers, explanations of benefits, copies of checks, and any and all other documents or information to (Provider) or its attorneys, employees or other representatives acting on behalf of (Provider). If the insurer schedules a defense examination, examination under oath (EUO) or Independent Medical Examination (IME) of the patient, the insurer is hereby instructed to send a copy of said notification to this provider and the provider's attorneys. The provider and/or the provider's attorneys are authorized to appear at any patient EUO or IME set by the insurer. THIS ASSIGNMENT OF BENEFITS DOES NOT ASSIGN ANY RIGHTS OR OBLIGATIONS UNDER THE POLICY OF INSURANCE, TO SUBMIT TO AN EUO OR RECORDED STATEMENT. I further direct and authorize you to speak to an attorney, employee or any other representative of (Provider) or anyone acting on their behalf over the phone and provide them with any and all information you may have or documentation not previously listed above that they may request.

I, as the patient, agree to remain personally liable for the amounts billed by (Provider) regardless of the amount paid by the insurance company, unless ordered by a court of law. I fully understand that said health care services were provided to me in consideration for an unconditional promise to pay and for me providing these instructions to my insurance company. I, as the patient, further agree to be liable for reasonable attorney's fees and costs incurred in collecting any delinquent accounts or unpaid balances. By executing this document, I am placing my insurance company(ies) on notice that the claims for medical treatment rendered by (Provider) are related to my accident (or my covered conditions) and should be paid directly to (Provider) pursuant to this assignment of benefits and Florida law. Any delay in paying benefits owed under the insurance policy could adversely affect me.

BY EXECUTING THIS DOCUMENT, I AM PLACING MY INSURANCE COMPANY ON NOTICE THAT THIS IS A DIRECT ASSIGNMENT OF BENEFITS PURSUANT TO FLORIDA LAW. AS THE INSURED OR BENEFICIARY OF SAID INSURANCE POLICY, I AM IRREVOCABLY ASSIGNING WHATEVER RIGHTS I HAVE UNDER MY POLICY OF INSURANCE (LESS THE DUTY TO ATTEND AN EUO) AND UNDER FLORIDA LAW TO THIS HEALTH CARE PROVIDER. A photocopy of this assignment shall be considered as effective and valid as the original.

Ins. Co. Name:_____ Provider ID:_____ Group Number: _____

_____ _____

Patient's Name DOB

_____

Printed Name of Policy holder or Claimant Acceptance of (Provider)

_____ _____

Signature of Policy holder or Claimant Date

PHOTO VIDEO RELEASE FORM

I, _____, hereby grant and authorize Acupuncture Fit the right to take, edit, alter, copy, exhibit, publish, distribute and make use of any and all pictures or video taken of me to be used in and/or for legally promotional materials including, but not limited to, newsletters, advertisements, press kits, websites, social networking sites and other print and digital communications, without payment or any other consideration. This authorization extends to all languages, media formats and markets now known or hereafter devised. This authorization shall continue indefinitely, unless I otherwise revoke said authorization in writing.

I understand and agree that these materials shall become the property of Acupuncture Fit.

I hereby hold harmless, and release Acupuncture Fit from all liability, petitions, and causes of action which I, my heirs, representative, executors, administrators, or any other persons may make while acting on my behalf or on behalf of my estate.

If the person signing is under the age of consent, then this release must be signed by a parents or guardian, as follows:

I hereby certify that I am the parent or guardian of _____ named above, and do hereby give my consent without reservation to the foregoing on behalf of this individual.

_____ _____

(Signature) (Date)