Child of Your Dreams Inc.

FERTILITY ACUPUNCTURE SERVICES

Client Information and Fee Agreement

For Embryo Transfer Acupuncture Services

Instructions:

Please complete and return the intake and fee/policy agreement. Please email, fax or mail the completed forms to the contact information listed below.

Please note that payment of $250 must be received BEFORE any services may be rendered for ON-SITE Pre and Post Embryo Transfer procedure.

You may call our office at to make a credit card payment for services. Or, you may mail your check or money order, payable to Child of Your Dreams.

If your Cycle is cancelled for any reason, you are entitled to a full refund less a $50 processing charge IF you notify our office up to 24 hours prior to the scheduled transfer.

By signing this document, client acknowledges the above fee agreement. The client further acknowledges that it is the client's ultimate responsibility to notify Child of Your Dreams of my exact scheduled embryo transfer for scheduling purposes.

ph: 303.665.4225
fax: 303.665.4227

email: spapuncture@aol.com
www.childofyourdreams.com

Consent for Treatment:

Acupuncture is the insertion of fine, sterile needles into specific points on the body and ears known as acupoints. You may experience tingling, warmth, heaviness, achy sensation, or numbness at the site of the insertion. Insertion is typically painless. Specific points for pre and post embryo transfer are being used to enhance the probability of pregnancy, although pregnancy cannot be guaranteed. Adverse effects of acupuncture include nausea, weakness, bruising, hematoma, breakage of needle, infection, pain, and discomfort. Our practitioners take great care in avoiding any aforementioned adverse effects. By signing below, client acknowledges understanding of this procedure and consents to same.

Privacy Notice:

We are in full compliance with HIPPA and the privacy act. A copy of our policy is kept on file for you to review. You will be provided with your own copy of this upon your written request. We do request permission to discuss the following information with the Staff at Conceptions, so please check the following boxes indicating your agreement for exchange of information:

____Your anticipated and actual retrieval and transfer dates
____The results of your retrieval, fertilization/embryology reports
____Ultrasound information pertaining to the uterine lining
____Number, Developmental stage and quality of embryos transferred
____Status of Pregnancy, Ultrasound Confirmation
____Any other information which may enhance our ability to better serve you to achieve your goal of pregnancy

We will not share ANY information with your insurance company or anyone else outside our staff and that of Conceptions Reproductive Associates.

_____By checking this box as an electronic signature, I agree to all of the above.

OR: You may sign here______________________________ Date______________

Kyle Liston c/o Child of Your Dreams Inc
1874 Grenfell Court • Erie, CO 80516

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Thank You...

for choosing our services.

It is the sincere hope of our staff that we can help you achieve the pregnancy you so desire.

We are honored to work with you.

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email: spapuncture@aol.com
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Kyle Liston c/o
Child of Your Dreams Inc
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Erie, CO 80516

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Name____

Address ____

____

Phone Numbers:

Home__________________________

Business________________________

Cell___________________________

____

Name and phone number of Emergency Contact

____

Name of Spouse/Significant other

Birth date____

Have you had acupuncture before?_______________________________

Allergies to Medications?______________________________________

Do you have any chronic health conditions we should know about?________

____

____

____

What is the medical diagnosis for your fertility difficulty?______________

____

____

____

Current Medications____

____

Tentative Retrieval Date______________________________

Actual Retrieval Date________________________________
(Once known, please contact us with this information)

Tentative Transfer Date ______________________________

Actual Transfer Date and Time_________________________
(Once known, please contact us with this information)

Are there any questions or concerns which you have prior to treatment?______

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