Ginger Reed, VMD, cVMA, CVMMP
Equipuncture, PLLC
Austin, TX

EQUIPUNCTURE
INTEGRATIVE VETERINARY SERVICES

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PATIENT ADMISSION FORM

Date: ___________ Owner/Agent: ___________________________________ Phone: ___________________ Email: __________________________________

Client Address: ____

Patient Name: ______________________________ Birth Year: ________ Breed: __________________ Color: ________________ Sex: ______________

Patient Location (if different): ____

Primary Veterinarian: ______________________________________ Would you like your horse's vet to be updated after appointments? YES / NO

Has your horse received any non-routine veterinary care in the last three years? YES / NO Reason(s): ________________________________

____

Do you grant permission to Equipuncture to post photographs of this horse on the practice's website and social media accounts? YES / NO

How did you hear about Equipuncture? ____

OWNER/AGENT AUTHORIZATION & CONSENT FOR ALTERNATIVE MEDICAL CARE WITH WAIVER OF LIABILITY

The classification of the treatment modalities by the Texas State Board of Veterinary Medical Examiners, as described in the Texas Administrative Code, Title 22, Part 24, Chapter 573 Subchapter B, §573.14 , §573.16, §573.17, §573.18 (Rules Pertaining to the Practice of Veterinary Medicine), have been explained to me, allowing me to fully understand and acknowledge that such treatment modalities are considered alternative forms of veterinary medicine. I elect to have Equipuncture, PLLC perform any of these modalities on my horse, including but not limited to:

- Acupuncture – including, but not limited to, dry needling, aqua-acupuncture, electro-acupuncture, hemo-acupuncture, pneumo-acupuncture, moxibustion, laser acupuncture, semi-permanent and permanent implantations
- Spinal Manipulation – including, but not limited to, veterinary medical manipulation, veterinary spinal manipulation, medical manipulation, equine veterinary medical manipulation, EVMM; and other manipulation deemed to be "chiropractic care"
- Therapeutic Laser – including, but not limited to, laser therapy, cold laser therapy, low level light therapy, laser acupuncture
- Herbal Medicine
- Equine Nutrition Consultation
- Sedation and restraint (if deemed medically necessary or beneficial during treatment)

Equipuncture, PLLC has explained and I understand the risks associated with these therapies (which may include worsening of the condition) and proceed with an informed consent, releasing Equipuncture, PLLC, and any treating professional associated with Equipuncture, PLLC from all liability related to these treatments. The applicable treatment techniques to be performed on the above patient have been adequately described and discussed with me. I have been made no guarantee or warranty regarding the success of prescribed treatment, and that Equipuncture, PLLC cannot ethically provide such guarantee. I have been made aware that positive effects of treatment may not be immediate and may require additional time and/or continued treatment.

I also agree to release Equipuncture, PLLC or any other treating professional associated with Equipuncture, PLLC from liability from any injury or damage to myself and my horse that may result from me providing assistance during these treatments. If I am unable or choose not to provide assistance during the treatments and Equipuncture, PLLC cannot perform the treatments alone, then I need to consider and exercise options and I acknowledge Equipuncture, PLLC is not liable for any adverse effects for advising me of such options.

I understand the nature of therapies and treatments provided by Equipuncture, PLLC to be generally safe with minimal side effects. However, in the rare event that adverse effects require additional medical treatment, raising the cost above the previously discussed rate, I understand any and all associated financial costs are my sole responsibility. I agree that any representative of Equipuncture, PLLC, including Dr. Virginia Reed, VMD, cVMA, CVMMP, shall not be held liable for any consequential damages resulting from such care, direct or indirect.

I understand that I am financially responsible for all services rendered by Equipuncture, PLLC and that full payment is due at the time of service. I agree and acknowledge I am financial obligated to pay any and all returned or declined check fees.

I certify that I have read and fully understand the above terms and conditions concerning the treatment of the patient above as well as my financial obligations. I acknowledge and accept that the treatments rendered by Equipuncture, PLLC is considered an alternative form of therapy in the state of Texas. I have been informed of the conventional treatments available and probable ability to cure the problem(s) discussed. I also certify that the Owner/Agent and Patient information provided above is accurate and that I have the authority to execute this consent.

Signature of Owner/Agent:____Date:_______________________