

# INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other complementary medicine procedures including various modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by the below named licensed acupuncturist and/or other licensed acupuncturist who now or in the future treats me while employed by, working or associated with or serving as a back-up for the treating acupuncturist named below, including those working at this office or clinic.

I understand that methods or treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese Massage), Chinese or Western herbal medicine and nutritional counseling.

I have had the opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture treatments and other procedures. Acupuncture attempts to normalize physiological functions, to modify and lessen pain syndromes, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needle sites that lasts a few days. Burns and/or scarring are a potential risk of moxibustion. There have been very rare instances reported of fainting, infection and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. Discoloration and redness of the tissues after cupping and gua sha are common, as these techniques move blood closer to the surface of the skin, but this should not be confused with bruising.

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. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal upset or allergic reactions to the herbs, I will inform the acupuncturist. I will also inform the acupuncturist if I become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment undertaken, and to modify treatment based upon the facts know about my case. I understand that administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content.

By signing below, I agree to the above- named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

To be completed by the patient:

Patient's Name \_\_\_\_\_  
PLEASE PRINT

Patient's Signature \_\_\_\_\_

Date Signed \_\_\_\_\_

Are you pregnant? (circle one) YES / NO

To be completed by the patient's representative, if necessary, e.g., if the patient is a minor or is physically or legally incapacitated:

Patient's Name \_\_\_\_\_  
PLEASE PRINT

Representative \_\_\_\_\_  
PLEASE PRINT

Relationship/Authority to Patient \_\_\_\_\_

Witness \_\_\_\_\_