PATIENT NAME:_____

ACUPUNCTURE INFORMED CONSENT TO TREAT

☐ 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.

☐ I understand that methods of treatment may include, but are not limited to: acupuncture, moxibustion, cupping, electrical stimulation, TuiNa (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. Herbs may also be in capsule form. I will immediately notify acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs.

☐ I have been informed that acupuncture is 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 on rare occasions, dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involved the use of heat lamps.

☐ 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 immediately the acupuncturist of any concerns.

☐ I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment and I understand the results are not guaranteed.

☐ I understand 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 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.

_____ _____ _____

Patient Signature (or Patient representative) Date (indicate relationship if signing for patient

_____ _____

Acupuncturist Signature Date