Informed Consent

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture and traditional Chinese medicine on me (or patient named below, for whom I am legally responsible) by the acupuncture practitioner named below and/or other licensed acupuncture practitioner serving as back-up for practitioner, whether signatories to this form or not.

I understand that the methods of treatment may include but are not limited to acupuncture, electrical stimulation, moxibustion, cupping, Tui-Na (Chinese Medical Massage), Oriental herbs and or Western nutritional supplements to promote health and well being, dietary and lifestyle counseling.

I have been informed that acupuncture is generally a safe method of treatment, but may have some side effects, including minor bruising, numbness or tingling near the sites that may last a few days, dizziness or fainting, a broken needle, or may produce temporary flare-up symptoms. Bruising is a common side effect of cupping. Fainting can most easily be avoided if patient takes care not to come to treatment when he or she is exhausted or hungry. To avoid needle breakage, patients must limit their movement while on the table. With sterile disposable needles there is no risk of HIV or hepatitis from the needles. Unusual risks of acupuncture are rare but include pneumothorax (lung puncture), nerve damage, organ puncture, and spontaneous miscarriage. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The acupuncture practitioner must be advised if the patient has a pacemaker, cardiac condition, bleeding disorder, history of seizures, is or may be pregnant.

I do not expect the acupuncture practitioner to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the practitioner to exercise judgment during the course of treatment, which based on the facts then known is in my best interest. While there are a number of alternatives that exist, the prognosis for treatment depends on the patient's condition, the duration and frequency of treatment and the responsiveness of the patient to both the treatment and the treatment plan. I understand that results are not guaranteed.

I understand that the practitioner and/or clinical 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 to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Printed Name _____

Patient Signature _____ Date _____
__Patient __Parent __Guardian

Witness Signature _____ Date _____