LOCKNEY ACUPUNCTURE

ACUPUNCTURE
STATEMENT OF INFORMED CONSENT

I hereby request and consent to the performance of acupuncture and other treatments within the scope of practice of an acupuncturist to be performed on me (or, if the patient is a minor, on the patient named below, for whom I am legally responsible) by Cari Lockney, L.Ac., and/or other licensed acupuncturists who now or in the future may treat me while employed by Lockney Acupuncture and Wellness Center.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Chinese herbal medicine, and nutritional counseling. I understand that there are minor risks associated with acupuncture treatment, including, but not limited to, slight bleeding and/or bruising of the skin. Bruising is a common side effect of cupping. I understand that the risk of infection is negligible when using sterile, single-use, disposable needles.

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 may be 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. I will notify a clinical staff member who is caring for me if I am, or become, pregnant, or if I am nursing.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications. I wish to rely on the acupuncturist to exercise good judgment during the course of the procedure, based on the facts then known, and act in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed.

I understand that I must fully inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released to any third parties without my written consent.

I have read the above consent, or have had it read to me, and I understand it. I have had the opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend for this consent form to cover the entire course of treatment for my present condition, as well as any future conditions for which I may seek treatment.