Acupuncture Consent Form

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with the information to assist me in making informed decisions. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effects on my health if I choose not to receive the medical care. It is expected that you are under the care of a primary care physician or medical specialist, the pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments and other procedure 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 indicated below and/or other licensed acupuncturist who now or in the future will treat me while employed by, working or associated with, serving as back-up for the acupuncturist named below, including those working at the clinic or the office listed below or any other office of clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine and nutritional counseling. I understand that the herbs may need to be prepared and the leas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but as with all types of healthcare interventions, there are some risks to care, including, but not limited to; bruising, numbness/tingling near the needling sites that may last a few days and dizziness or fainting. Burns and/or scarring are a potential risk of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax) infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risk 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. I will discontinue all herbs and supplement t until I have consulted and received advice from my acupuncturist and/or OBGYN. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, liver or kidney damage, headache, diarrhea, rashes, hives and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgement during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best

interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must 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 without my written consent.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but not limited to, self-administered care, over the counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injection and surgery Lastly, I understand that I have the right to a second opinion and secure other options about my circumstances and healthcare as I see it.

By voluntarily signing below, I confirm that I have read, or have 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 agree with the current or future recommendations for care. 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.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient name:

Acupuncturist name:

Patient signature: _____ Date:_____

(Or patient representative)