MetroWest Family Acupuncture

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(s) who now or in the future treat me. I understand that the methods of treatment may include, but are not limited to, acupuncture, moxibustion (the therapeutic use of thermal stimulus at acupuncture points), cupping, electroacupuncture, electrical stimulation acupuncture and nutritional counseling. I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects including slight pain or discomfort at the site of the needling, bruising, numbness or tingling, burns, weakness, nausea, dizziness, or temporary aggravation of symptoms existing prior to treatment. Unusual side may effects include: spontaneous miscarriage, fainting, infection, organ puncture or nerve damage.
I will inform my acupuncturist(s) if I become pregnant or am in the process of trying to become pregnant.

“With this knowledge, I voluntarily consent to the above treatments.”

_____
Printed Name

_____
Patient Signature (or Patient Representative)

_____
Date