INFORMED CONSENT

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 no limited to, acupuncture, moxibustion (the therapeutic use of thermal stimulus at acupuncture points), cupping, electrical stimulation, Gua Sha, Tui-Na (Chinese massage), 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 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. I also understand that I must inform this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the- counter).

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

_____

Printer Name

_____

Patient Signature (or Patient Representative)

_____

Date

_____

Witness