MICHELLE MANTO
Berkshire Acupuncture & Wellness
Helping People Heal

INFORMED CONSENT TO TREATMENT

Name: _____ Today's date: _____

I understand that acupuncture involves the stimulation of a certain point or points on or near the surface of the body by the insertion of special needles to prevent or modify the perception of pain and/or to normalize physiological functions, for the treatment of certain diseases and/or body dysfunctions. Treatment with acupuncture may include, but is not limited to, the following side effects: possible aggravation of existing symptoms, numbness, tingling, heaviness and slight discomfort. In addition, because of the complexity of the body and its blood supply routes, I understand that there is an extremely small chance of local bruising and minor bleeding. I understand that I can stop acupuncture at any time.

I understand that, in addition to Acupuncture, Traditional Chinese Medicine may include various treatment options to help prevent or modify the perception of pain and/or to normalize physiological functions and for the treatment of certain diseases and/or body dysfunctions. Treatment with Traditional Chinese Medicine may include, but is not limited to, food and nutritional therapy, Chinese herbal medicinals, warming moxibustion, cupping and gua sha (treatments to improve circulation and remove toxins), tuina massage, electro-acupuncture and topical liniments, oils and plasters. Side effects may include, but are not limited to: possible aggravation of symptoms, bruising, burning, sore muscles, and discomfort. I understand that I can refuse any treatment option at any time.

I understand that the information I have given today is correct and to the best of my ability and knowledge. I also understand that this information will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes in my medical status.

I understand that, unless a situation arises beyond my control, I am required to give, at least, a 24 hour notice for cancelling an appointment. Otherwise, I will be responsible for payment of the missed appointment. I understand that payment is due at time of service unless otherwise agreed upon before treatment begins.

I, _____, therefore consent, authorize and request to be treated with Acupuncture and Traditional Chinese Medicine by this office. In addition, I authorize the staff to perform any services deemed advisable and/or necessary to my condition during diagnosis and treatment. This consent form will remain in effect for all appointments and treatment now and in the future.

_____ _____
Patient Signature Date