



The Health Institute of Hampstead  
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## Consent to Acupuncture Treatment

By signing below, I do hereby voluntarily consent to be treated with acupuncture and Traditional Chinese Medicine by a NC Licensed Acupuncturist at The Health Institute of Hampstead. I understand that acupuncturists practicing in the state of NC are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended.

I hereby authorize and direct The Health Institute of Hampstead and its delegate licensed affiliates to perform acupuncture and oriental medicine procedures such as obtaining a health history, performing pulse and tongue evaluation, manual palpation, observation, range of motion evaluation, skin, muscle, abdominal (hara) and "Chi" assessment, modes of manual or natural therapy, such as massage TuiNa, Shiatsu, heat and/or cold therapy, the use of magnets and electrical stimulation, Onnetsu therapy, cupping, topical application of liniments, dietary recommendations and advice regarding lifestyle and exercise.

Acupuncture needling treatment will consist of the insertion of sterile disposable needles at specific sites on the body. Stimulation of said needles may be achieved by hand manipulation, electrical stimulation or the application of warming substances (moxa) on the needle itself.

I have had the opportunity to discuss questions with my practitioner, regarding the nature and purpose of acupuncture and oriental medicine procedures. I understand that although acupuncture and oriental medicine procedures have helped many people, no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of western medicine, in the practice of Oriental Medicine there are some risks to treatment. I understand that the risks include but are not limited to; bleeding, bruising, light-headedness, inflammations, infections, general aches, burns, discomfort at the location where the needle was inserted or radiating from that location and temporary aggravation of current symptoms. I do not expect the practitioner to be able to anticipate and explain all risks and complications, and during the course of treatment I wish to rely on the practitioner's judgment based on the facts known at the time.

I, \_\_\_\_\_, certify that I have read and understood the above consent. I also certify that I have informed my acupuncturist of all known physical, mental and medicinal conditions and medications, and I will keep him/her updated on any changes. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_