Downtown Gilbert Healthcare **Consent Form For Acupuncture Treatment**

I understand that I will be receiving acupuncture for the treatment of my health condition. I understand that acupuncture treatments in the state of Arizona are not a primary health care modality. I understand that seeing an acupuncturist for treatment does not replace seeing my primary care physician. I understand that, if I am referred by my primary care physician for acupuncture, I will return to my primary care physician for follow-up as needed.

I hereby request and consent to the performance of acupuncture treatment and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible), by the practitioner named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the practitioner named below, including those working at the clinic or office listed below.

I understand that the methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), and nutritional counseling.

Potential Risks // I understand that the potential benefits of acupuncture include drugless relief of my symptoms and an improved state of health. I have been informed that acupuncture is a generally safe method of treatment, but that I may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, 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. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and 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 on the facts then known is in my best interest. I understand that results are not guaranteed.

Pregnancy // I will notify a clinical staff member if I am or if I become pregnant.

With my understanding of the above, I voluntarily consent to receive acupuncture treatment.

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Print Name of Patient Signature of Patient or Legal Guardian

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Date Name of Treating Clinician