Ellison Acupuncture

I. PATIENT ADVISORY TO CONSULT A PHYSICIAN

The practitioners at Ellison Acupuncture are committed to your health and well-being. We believe that Oriental Medicine has a great many benefits but it is not meant to replace the resources available to you through biomedical physicians. Therefore, we recommend that you consult a physician regarding any condition or conditions for which you are seeking acupuncture treatment.

To comply with Article 160, Section 8211.1 (b) of NYS Education law, we request that you read and sign the following statement.

We, the undersigned, do affirm that (please print name of patient) **has been advised by Ellison Acupuncture, to consult a physician regarding the condition for which such patient seeks acupuncture treatment.**

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Patient signature

II. Informed Consent to Acupuncture Treatment

I consent to acupuncture treatments and other procedures associated with the practice of traditional Oriental Medicine provided by the practitioners at Ellison Acupuncture.

I understand that methods of treatment may include but are not limited to acupuncture, moxibustion, cupping, electric stimulation, and bodywork therapies such as Neuromuscular Therapy, Myofascial Release, Visceral Manipulation Techniques, and Tui Na.

I have been informed that acupuncture is a safe method of treatment but that it may have side effects, including bruising, numbness, or tingling near the needling sites that may last a few days. Other side effects may include dizziness and fainting. Bruising is a common side effect of cupping. Rare and unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk. This site uses sterile, disposable needles and maintains a clean and safe environment to avoid infection. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document explains the major risks of treatment, other side effects and risks may occur.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment.

To be completed by patient (or patient's representative if patient is a minor or is physically or legally incapacitated).

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Date Consent Completed

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Signature of Patient