Informed Consent to Receive Acupuncture

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 professional practitioners, and/or intern practitioners who now or in the future treat me while employed by, working, or associated with AIMC Berkeley or Nicholas Collins PAC LAC INC serving as back-up, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, electrical stimulation, shiatsu (Oriental massage), lifestyle advice and nutritional counseling.

I have been informed that acupuncture is generally safe method of treatment, but that it may have some side effects, including bruising, numbness, or tingling near the needling sites that may last a few days; dizziness; or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although AIMC Berkeley uses sterile disposable needles and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I will notify the professional practitioner and/or intern practitioner who is caring for me if I am or become pregnant.

If I am receiving treatment from an intern practitioner, I understand that treatment will be administered by a professional licensed by the State of California, who is also a student currently enrolled in the Doctorate in Acupuncture and Integrative medicine degree program and clinical training program at the Acupuncture and Integrative Medicine College. The licensed professional's work will be managed and audited by a Physician's Assistant and a senior licensed acupuncturist.

I do not expect the clinical staff, professional practitioners, and/or intern practitioners to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the professional practitioners and/or intern practitioners to exercise judgement during the course of treatment, based upon the facts then known, in my best interest. I understand that results are not guaranteed.

I understand that the clinical and administrative staff may review my patient records and lab reports, but that all my records will be kept confidential and will not be released without my written consent. I understand that under certain circumstances, my treatment may take place in a semi-private or open treatment setting where my conversations with the practitioner may be overheard by other patients or staff.

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

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Signature of patient or Responsible Party Date