Bishop Physical Therapy

1203 US Highway 98 Suite 1C

Daphne AL 36526

INFORMED CONSENT TO ACUPUNCTURE TREATMENT AND CARE

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 the licensed acupuncturist employed by Bishop Physical Therapy.

I understand that methods of treatment may include, but are not limited to, acupuncture, cupping, and electrical stimulation. I have been informed that the results are not guaranteed.

I understand and am informed that, as in the practice of medicine in the practice of in the practice of acupuncture, there are some risks to treatment, including, but not limited to, nausea, bruising, soreness, fatigue, and dizziness. I understand that while this document describes the major risk of treatment, other side effects and risks may occur. I do not expect the acupuncturist to be able to anticipate and explain all risk and complications, and wish to rely on the acupuncturist to exercise judgement during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interest.

I understand the clinical and administrative staff may review my patient records, but all of my records will be kept confidential and will not be released without my written consent.

I have read, or have had read to me, the above consent. I have been told about the risk and benefits of acupuncture and other procedures and have had the opportunity to ask questions, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any condition(s) for which I seek treatment.

Patient's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____