Acupuncture Informed Consent To Treat

I HERBY 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 ACUPUNCTURIST 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 ACUPUNCTURIST NAMED BELOW, 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, MOXIBUSTION, CUPPING, ELECTRICAL STIMULATION, TUI-NA (CHINESE MASSAGE), CHINESE HERBAL MEDICINE, OZONE THERAPY, ATP BIORESONANCE THERAPY, RED LIGHT THERAPY, INJECTION THERAPY, LOW LEVEL LASER THERAPY, ULTRASOUND, ITERACARE THERAPY AND NUTRITIONAL COUNSELING. I UNDERSTAND THAT THE HERBS MAY NEED TO BE PREPARED AND THE TEAS CONSUMED ACCORDING TO THE INSTRUCTIONS PROVIDED ORALLY AND IN WRITING. THE HERBS MAY BE AN UNPLEASANT TASTE OR SMELL. I WILL IMMEDIATELY NOTIFY A MEMBER OF THE CLINICAL STAFF OF ANY UNANTICIPATED OR UNPLEASANT EFFECTS ASSOCIATED WITH THE CONSUMPTION OF THE HERBS.

I UNDERSTAND THAT ACU-POINT INJECTION THERAPY INVOLVES INJECTION OF VITAMINS, HERBS, HOMEOPATHIC, AND OTHER NUTRITIONAL SUPPLEMENTS IN THE FORM OF STERILE SUBSTANCES, USING STERILE, SINGLE-USE HYPODERMIC NEEDLES. I UNDERSTAND WITH ALL INJECTIONS, THEY MAY CAUSE PAIN OR REDNESS AT THE SITE OF INJECTION. ALTHOUGH THIS IS RARE. SOMETIMES YOU MAY ALSO BRUISE AT THE SITE OF INJECTION. IF YOU HAVE ANY CONCERNS AFTER THE INJECTION WITH SWELLING OR REDNESS, PLEASE CALL THE OFFICE IMMEDIATELY. IF IT IS AFTER-HOURS, PLEASE GO TO THE EMERGENCY ROOM IF YOU ARE HAVING DIFFICULTY BREATHING OR ANY OTHER SERIOUS REACTION.

I HAVE BEEN INFORMED THAT ACUPUNCTURE IS A 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, 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 A POTENTIAL RISK OF MOXIBUSTION AND CUPPING. I UNDERSTAND THAT WHILE THIS DOCUMENT DESCRIBES THE MAJOR RISKS OF TREATMENT, OTHER SIDE EFFECTS MAY OCCUR. THE HERBS AND NUTRITIONAL SUPPLEMENTS (WHICH ARE FROM PLANT, ANIMAL AND MINERAL SOURCES) THAT HAVE BEEN RECOMMENDED ARE TRADITIONALLY CONSIDERED SAFE IN THE PRACTICE OF CHINESE MEDICINE, ALTHOUGH SOME MAY TOXIC IN LARGE DOSES. I UNDERSTAND THAT SOME HERBS MAY BE INAPPROPRIATE DURING PREGNANCY. SOME POSSIBLE SIDE EFFECTS OF TAKING HERBS ARE NAUSEA, GAS, STOMACH ACHE, VOMITING, HEADACHE, DIARRHEA, RASHES, HIVES AND TINGLING OF THE TONGUE. I WILL NOTIFY A CLINICAL STAFF MEMBER WHO IS CARING FOR ME IF I AM OR BECOME PREGNANT.

I DO 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 UPON THE FACT THEN KNOWN IS IN MY BEST INTEREST. I UNDERSTAND THAT RESULTS ARE NOT GUARANTEED.

I UNDERSTAND THE CLINICAL AND ADMINISTRATIVE STAFF MAY REVIEW MY PATIENT RECORDS AND LAB REPORTS, BUT ALL MY RECORDS WILL BE KEPT CONFIDENTIAL AND WILL NOT BE RELEASED WITHOUT MY WRITTEN CONSENT.

BY VOLUNTARILY SINGING BELOW, I SHOW 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 OTHER PROCEDURES, AND HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS. I INTEND THIS CONSENT FORM TO COVER THE ENTIRE COURSE OF TREATMENTS FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK TREATMENT.

SIGNATURE ______________________________ DATE ______________________

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

INDICATE RELATIONSHIP IF SIGNING FOR PATIENT

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