

CONSENT FORM FOR ACUPUNCTURE TREATMENT

I hereby consent to Traditional Chinese Medicine (TCM) procedures on myself (or person named below who I am the parent/guardian) by a board certified and licensed acupuncturist (LAc).

I understand the methods of treatment may include, but are not limited to: acupuncture, moxibustion, cupping, bleeding, gua sha/scraping, electrical stimulation, and Tui Na (Chinese Massage). I have had the opportunity to discuss with the above named acupuncturist (LAc) the nature and purpose of acupuncture treatments and other procedures.

I have been informed that acupuncture is a safe method of treatment that may have side effects which include: bruising, numbness or tingling near the needling sites that may last a few days, and possible dizziness or fainting. Bruising is a common, and desired side effect of both cupping and gua sha/scraping. Unusual risks of acupuncture include: nerve damage, organ puncture (including lung puncture/pneumothorax), spontaneous miscarriage, and infection (which has low risk due to sterile needles).

I will notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the licensed acupuncturist (LAc) to exercise good judgment during the course of the procedure which the practitioner feels, based on the facts then known, to be in my best interests.

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

I have read, or have read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures.

I intend this consent form to cover the entire course of treatment with my practitioner.

Printed Name, Signature, Date

WITNESS:

Printed Name, Signature, Date