chiro-health chiropractic

ACUPUNCTURE INFORMED CONSENT TO TREATMENT

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 acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as backup for the acupuncturist named below, including those working at the clinic or office listed above or any other associated office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, Tui Na (Chinese massage), cupping, electrical stimulation, moxibustion and nutritional counseling.

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. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. 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.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I will notify my acupuncturist or a member of her clinical staff who is caring for me if I am or become pregnant.

While I do not expect my acupuncturist or members of her clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on my acupuncturist/clinical staff to exercise judgment during the course of treatment which my acupuncturist/clinical staff thinks at the time, based upon the facts 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 signing 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 treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____Agatha Suk, LAc._____

Name (PLEASE PRINT) Acupuncturist's Name (PLEASE PRINT)

_____ _____

Signature of patient or representative Signature of Acupuncturist

Date _____

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