Acupuncture Consent to Treatment

I hereby authorize and consent to the performance of acupuncture treatments and other Oriental medical procedures on me (or on the patient name below, for whom I am legally responsible) by the below-named licensed acupuncturist.

I understand that methods or a treatment or treatments may include but are not limited to the insertion of sterile acupuncture needles, moxibustion, cupping, Gua Sha (a Chinese massage technique that may produce redness on the skin for 1-5 days), bloodletting, electrical stimulation, Tui Na (Chinese massage), Chinese or Western herbal medicine, and nutritional counseling.

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that may have been recommended are traditionally considered safe in the practice of Oriental medicine. I understand that the same herbs may be inappropriate during pregnancy and will immediately inform my practitioner of my pregnancy status. If I experience any gastrointestinal reactions to the herbs I will immediately inform the acupuncturist.

I have been informed that I have the right to refuse any form of treatment. I have read, or have had read to me the above consent. I understand the nature of treatment, have been informed of the risks and possible consequences involved with this treatment, and was given the opportunity to ask questions pertaining to my treatment. I understand that there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. I intend this consent form to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment. __________ (initials)

I understand that it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records for reasons listed above. __________ (initials)

I agree to pay the full charge for any missed or forgotten appointments without 24 hours' notice of cancellation. ___________ (initials)

I agree to pay all charges incurred for services rendered. __________ (initials)

____
Patient's Name

____
Patient's Signature

____
Patient's Representative

____
Date Signed

____
Relationship or Authority of Patient

____
Practitioner's Signature

____
Witness

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