

Informed Consent for Acupuncture Treatment and Care

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures by the below named licensed acupuncturist and/or other licensed acupuncturist who now or in the future treat me while employed by, working or associated with or serving as a back-up for the treating acupuncturist named below, including those working at his office/clinic or any other office or clinic.

I understand that methods or treatment may include, but are not limited to, acupuncture, moxibustion, cupping, gua sha, electrical stimulation, Tui-Na {Chinese massage}, Chinese or Western herbal medicine, and nutritional counseling.

I have had the opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture treatments and other procedures.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that can last a few days. There have been very rare instances reported of fainting infections and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping or gua sha.

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. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastro-intestinal upset or allergic reactions to the herbs, I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications. I wish to rely on the acupuncturist to exercise judgment 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 medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that my appointment times are my commitment to being here and I agree to cancel 24 hours in advance or I will pay for the treatment.

I have read, or have had read to me, the above consent. I have also had an 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 for my present condition and for any future condition {s} for which I seek treatment.

To be completed by the Patient:

Patient's Name _____

Patient's Signature _____

Date Signed _____

Are you Pregnant { } Yes { } No

To be completed by the patients Representative, if
Necessary
E.G., if the patient is a minor or is physically or legally
incapacitated:

Name of Patient _____

Patient's Representative _____

Relationship or Authority of patient _____

Witness- _____

Name of Acupuncturist: Patty Kuchar, L.,Ac