Informed Consent to Acupuncture Treatment

I hereby request and consent to the performance of acupuncture treatment and other procedures within the scope of the practice of acupuncture (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 the acupuncturist named below, including those working at the clinic or office listed below. I have read the information about the provider's education and background on the provider's website. I understand and agree with the fee schedule for the service.

I understand that methods of treatment may include, but are not limited to, acupuncture, cupping, *gua sha*, electrical stimulation, *tui na* (Chinese medical massage), Chinese herbal medicine, and life-style and nutritional couching. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided in writing. Some herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinic staff of any unanticipated or unpleasant effects associated with the consumption of the herbs to help modify my prescription. I understand that this clinic complies with the rules and regulations promulgated by the Colorado Department of Public Health and Environment, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are used.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including but not limited to bruising, numbness or tingling near the needling sites that may last a few days, and dizziness palpitations or fainting. Bruising is a common side effect of cupping and *gua sha*. Unusual risks of acupuncture include but are not limited to spontaneous miscarriage, nerve damage and organ puncture. Infection is another possible risk, although the clinic uses clean needle technique, *sterile, disposable* needles, and maintains a safe, clean environment. Burns and/or scarring are a potential risk of cupping. I understand that while this document describes the major risks of treatment, other side effects and risks 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 be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify the clinic staff member who is caring for me immediately if I am, or become pregnant.

I do not expect the clinic 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 judgment during the course of treatment which the clinic 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 clinic and administrative staff may review my patient records and reports, but all my records will be kept confidential and will *not* be released *without* my written consent. I understand the patient's rights.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment. I have been told about the risks and benefits of acupuncture and other procedures, and I 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 at this clinic.

Female ONLY: Are you pregnant or nursing? ☐ Yes ☐No If *yes*, please check one: ☐ pregnant ☐ nursing

Patient's Name (PLEASE PRINT) **Patient's or Responsible Party's Signature** **Date**

If signed by Responsible Party, please provide below information:

Name (PLEASE PRINT) **Relationship to patient** **Witness**

BELOW IS FOR OFFICE USE ONLY

Clinician's Name (PRINT) **Clinician's Signature** **Date**