Healing Care Acupuncture

105 W. North College Street, Suite 10
Yellow Springs, OH 45387

ACUPUNTURE INFORMED CONSENT TO TREAT

I hereby voluntarily request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of an acupuncturist to be performed by *Sharmine N. Lynch, L.Ac.*, representing Healing Care Acupuncture, on me (or on the patient named below, for whom I am legally responsible).

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Gua-Sha, and supplemental techniques.

I understand that acupuncture is a generally safe method of treatment, but that it may have some side effects that include, but are not limited to, unusual dizziness or fainting, temporary bruising, pain or discomfort, soreness, swelling, bleeding, numbness or tingling near the needling sites that may last a few days. Burns, blistering, 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 the acupuncturist if I am or become pregnant or if I am in the process of trying to become pregnant.

While I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, to be in my best interest.

I understand that acupuncture is not a substitute of conventional medical diagnosis and treatment and that I have the opportunity to discuss the nature and purpose of acupuncture and treatments with the practitioner at any time during my care. I understand that there is no implied or stated guarantee of cure or improvement of my condition.

I understand the acupuncturist 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.

I understand that scheduling an appointment reserves a time specifically for me, and that consequently, a minimum of 24 hour notice is required to reschedule or cancel an appointment. If I do not call or show up, I will be responsible for the missed session fee.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent for treatment, acknowledge 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.

_____ _____

Patient's Name (Please Print) Patient's Signature Date

_____ _____

Print Name of Patient's Representative (If Applicable) Relationship to Patient

_____ _____

Signature of Patient's Representative (If Applicable) Date