**COMMUNITY ACUPUNCTURE INFORMED CONSENT TO TREAT**

I give consent to receive acupuncture treatment (for myself or for the patient named below, for whom I am legally responsible) performed by the acupuncturists at Casa Grande Community Acupuncture. I understand that this clinic only practices acupuncture and that if I so desire herbal medicine or adjunct Chinese therapies I can ask for a referral.

 I understand that acupuncture involves the insertion of fine needles at specific points on the body. Acupuncture is generally considered to be a very safe method of treatment, but I understand that side effects can occur. Possible side effects of acupuncture include bruising, bleeding, numbness or tingling near the needling sites that may last a few days, dizziness, and fainting. Unusual risks of acupuncture include infection, spontaneous miscarriage, seizures, nerve damage, and organ puncture, including lung puncture (pneumothorax). To minimize the risk of infection, CGCA uses sterile, single-use acupuncture needles and maintains a clean and safe environment.

 I understand that while this form describes major risks of treatment, other side effects and complications may occur. I do not expect the acupuncturists to be able to anticipate or explain all possible risks and complications of treatment. I understand that results are not guaranteed.

 I understand that CGCA provides acupuncture in a community setting. The purpose of this setting is to allow as many people as possible to access treatment and to decide for themselves how they wish to use acupuncture to manage their health. Common side effects of acupuncture treatment in a community room include deep relaxation, falling asleep, and snoring. I understand that if I need to be woken up at a certain time, I will let the reception staff and the acupuncturist know. I understand that I might be too relaxed to drive immediately after treatment. If other people’s snoring bothers me, I understand that I need to bring earplugs or headphones. I understand that at times, someone else might be sitting in my favorite recliner. I understand that community acupuncture involves actual community with a wide variety of people, and may at times require some flexibility, patience, or understanding from me.

 I understand that acupuncture is a process, and that results will be best when I receive acupuncture regularly and as frequently as my acupuncturist recommends. I will ask my acupuncturist if I have questions about my treatment or about the risks and benefits of acupuncture. I will notify an acupuncturist if I am or become pregnant.

I understand that my records will be kept confidential and will not be released without my written consent. Clinical and administrative staff may review my records as needed.

 I have read this information (or had it read to me), and I have had an opportunity to ask questions. By signing below I voluntarily give consent to receive acupuncture as treatment for my present condition and for any future conditions.

Signature of Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(or Patient Representative)

Name of Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_