Informed Consent to Acupuncture Treatment

I consent to acupuncture treatments and other procedures associated with the practice of Traditional Oriental Medicine by the licensed acupuncturist. I have discussed the nature and purpose of the treatment with the licensed acupuncturist named below.

I understand that methods of treatment may include but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, and bodywork therapies.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. 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 this Practice uses sterile, disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. 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), which may be 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, diarrhea, rashes, hives and tingling of the tongue.

I understand that herbs need to be prepared and the tea consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant taste or smell.

I will immediately notify the licensed acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I will notify the licensed acupuncturist who is caring for me if I am or become pregnant.

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

Both the patient and the licensed acupuncturist understand sexual intimacy is never appropriate and should be reported to the NYS Education Department at The New York State Office of Professions, Cultural Education Center, Room 3007, Albany, New York, 12230.

All of our records will be kept confidential and will not be released to any party without my written consent, unless reasons fall under the exceptions in the HIPAA privacy policy.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about 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.

_____	X _____
Date Consent Completed	Print Name of Patient
Nancie Forrest, L.Ac.	Y _____
Print Name of Licensed Acupuncturist	Patient or Representative Signature
_____	_____
Licensed Acupuncturist Signature	Print Name of Patient Representative (if applicable)

X
Email: _____

Would you like to receive correspondence from me in future? Please circle yes or no. Y N