Safarik Wellness, LLC | 6314 Odana Rd Ste 22 Madison, WI 53711
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Informed Consent for Acupuncture Treatment and Care

Methods or treatment may include, but are not limited to: Acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na, Chinese herbal medicine, manual therapy & stretching.

Purpose of Treatment: Acupuncture attempts to normalize physiological functions, to reduce pain, and to treat certain diseases or dysfunctions of the body.

Risks of Treatment: Acupuncture and herbal medicine are traditionally considered safe methods of treatment. However, there are uncommon but potential risks, which include:

- Discomfort during the insertion of a needle.
- Dizziness or fainting
- Minor bruising or temporary discoloration of the skin
- Minor burns with the usage of some types of moxa
- Temporary aggravation of symptoms that existed prior to treatment
- A broken needle or infection (very rare with use of disposable needles)
- Gastro-intestinal upset with the use of Chinese herbs (Please notify practitioner if this should occur.)

Special Situations: Some herbs and acupuncture points are contraindicative under certain situations. Please notify your practitioner **PRIOR TO TREATMENT** if you are **pregnant,** if you have **severe bleeding disorders**, or if you are wearing a **pacemaker or other electronic medical device.****

Medical Records: Patient records and patient information will be kept confidential within Safarik Wellness, LLC and shared only when necessary to provide care and services, or by patient authorization, or when required or permitted by law.

Cancellation Policy: Our clinic requires a **24-HOUR NOTICE OF CANCELLATION.** All appointments that are cancelled with less than 24-hour advance notice, and appointments that are missed without notice, will be charged the regular fee for that appointment.

I, _____ request and consent to receiving acupuncture treatments and other complementary medicine procedures (or on the patient named below, for whom I am legally responsible) by Matt Safarik, Lac and Safarik Wellness, LLC. I have read, or have had read to me, and comprehend, the preceding information. I have had an opportunity to ask questions about its content. I understand that the practitioner is not 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 interests.

I, _____ understand that there is a 24-hour cancellation policy and that if I do not adhere to the policy, I will be responsible for paying the regular fee for the missed appointment.

I, _____ release Safarik Wellness, LLC and its practitioners from any and all liability that may occur in connection with the above-mentioned procedures.

Patient's Name (Please Print) _____

Patient's Signature_____ Date _____

_____

Consent To Treat A Minor Child: I authorize Safarik Wellness, LLC to administer Acupuncture, Massage Therapy and Traditional Chinese Medicine as deemed necessary to:

Child's printed name: _____

Adult's printed name: _____ relationship to child _____

Adult's signature _____