Acupuncture Informed Consent to Treat

I hereby request and consent to the performance of acupuncture treatment and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the licensed naturopathic physician named and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for West Valley Naturopathic Center. This includes those working at the clinic or office below or any other office or clinic, whether signatories to this form or not.

I understand that the methods of treatment may include but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Chinese herbal medicine and nutritional counseling.

I have been informed that acupuncture is a generally safe method of treatment, but that I may experience some side effects, including: bruising, numbness, tingling near the needling sites that may last a few days, dizziness and/or fainting. Bruising is a common side effect of cupping. Unusual risk of acupuncture includes 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. Burns and/or scaring are a potential risk of moxibustion or 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, stomach ache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate or explain all possible risk and complications of treatment. I wish to rely on the judgement of clinical staff, based upon current symptoms and facts, to determine the appropriate course of treatment for me. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent for treatment, I have been told about the risks and benefits of acupuncture and other procedures and have had an opportunity to ask questions. It is understood that this consent form covers the entire course of treatment for my present condition as well as any future condition(s) for which I seek treatment.

Patient Name (Printed): _____

Date of Birth: _____

Today's Date: _____

Patient Signature:_____

Patient Representative (print): _____

Signature of Patient Representative：_____