Acupuncture Information and Informed Consent

Acupuncture is performed by the insertion of ***pre-sterilized, disposable*** acupuncture needles through the skin, and/or the application of heat or electrical stimulation to the skin, or both, at certain points on the body. The benefits and risks of receiving acupuncture and Oriental Medical treatment have been explained to me. Although rare, certain side effects may result from acupuncture, I understand that each procedure or treatment has specific risks and benefits. I understand that the Acupuncture Wellness Center may record medical and other information concerning my treatment in electronic and other physical forms. Such information may be released by the practice according to state and federal laws. I understand that the practice of acupuncture and Oriental Medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in Alternative Healing.

I have been informed of the risks and benefits of the procedures and products listed below that apply to my treatment:
Acupuncture needles to stimulate points and meridians, including specific risks of needling certain points. The use of mechanical, magnetic or electrical stimulation of acupuncture points, particularly in instances where such stimulation is applied across the midline of the trunk or in patients with a history of heart trouble, moxabustion, herbs, laser puncture (cold laser used to stimulate acupuncture points), acupressure, massage, nutrition and food therapies.

I have been informed and understand the risks and side effects listed below:

- Minor bruising
- Needle sickness
- Broken needles
- Some pain at the site of needle insertion
- Infection
- Risks from needling in the vicinity of an infection
- Potential side effects of nutritional supplements and herbs.

Records Release Authorization

I understand that I am responsible for my bill
I authorize payment directly to my practitioner
I authorize release of information to all my insurance companies
I permit a copy of this authorization to be used in place of the original
I direct my previous health care providers to release medical records to this practice
This authorization is not intended to allow the release of records regarding my treatment for services requiring a restricted release under State or Federal law.

Patient's Signature_____ Date_____

Witness Signature_____ Date_____

Consent to Treat a Minor Child

I authorize Cindy Campbell and whomever he/she designates as assistants to administer Acupuncture and Oriental Medicine care as deemed necessary to my _____(relationship)

Patient's Name_____

Adult's Signature_____ Date_____

Effective 1/10/04