PATIENT CONSENT FOR ACUPUNCTURE TREATMENT

Patient Name:_____

I hereby, being over 18 years of age (or legal representative if patient is a minor), request and consent to that acupuncture treatment performed on me (or the patient named above) by the licensed acupuncturist employed by or associated with this clinic.

I understand that, pursuant to New York State Education Law, Article 160, section 8211, the practice of acupuncture involves the insertion of sterile disposal needles through the skin and the application of the body for the purpose of achieving a therapeutic or prophylactic effect.

I am aware that although acupuncture has been shown clinically effective in many conditions, no guarantees concerning its use or effects have been given to me.

I also understand that since acupuncture treatment is based on the traditional theory of healing, a licensed acupuncturist will make no medical diagnosis, and I have been advised to consult a physician regarding the condition of conditions for which I seek acupuncture treatment.

I have been informed that although acupuncture is a generally safe method of treatment, certain adverse side affects may result. These could include,but are not limited to, pain, tingling, drawing a few drops of blood, slight bruising near the acupuncture site, or temporary aggravation of the existing symptoms. There have been reported very rare instance of fainting, infection, and scurrying.

I hereby wish to rely on the acupuncturist's professional judgment to decide on the course of the acupuncture treatment that based upon the facts then known, is beneficial to me. I am free to stop acupuncture treatment at anytime.

For women only: Pregnant:___Yes,___No I will inform the acupuncturist if I become pregnant.

I have the opportunity to discuss with the acupuncturist or other clinic personnel the benefits, contraindications, and side affects of the acupuncture procedure, and the content of this content form.

We, the undersigned, do affirm that _____(patient) had been advised by,_____(Licensed Acupuncturist), to consult a physician regarding the condition or conditions for which such patients seeks acupuncture treatment.

Patient's Signature:_____ Date:_____

Acupuncturist Signature:_____ Date:_____

Patient's guardian must sigh, if the patient is less than 18 years old.

Print:_____ Sign:_____

(Patient's guardian) (patient's signature)