

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I, \_\_\_\_\_, hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me, \_\_\_\_\_ by the acupuncturist below who now or in the future treat me while working in Union Square acupuncture clinic, including those working at this office or any other office or clinic, whether signatories to this form or not. I understand the methods of treatment may include, but are not limited to, acupuncture, acupressure, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. 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 few days and dizziness or fainting. I understand that I should not move while the needles are being inserted, retained, or removed. 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 the acupuncturist below 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, mineral, and animal 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, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

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

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.

Patient's Name \_\_\_\_\_ Are you pregnant? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

Name of Acupuncturist: Jeonhee Jang Union Square Acupuncture Clinic

To be completed by the patient's representative if the patient is a minor or is physically or legally incapacitated:

Print Name of Patient \_\_\_\_\_

Print Name of Patient Representative \_\_\_\_\_

Signature of Patient Representative \_\_\_\_\_ Date \_\_\_\_\_

Relationship or Authority of Patient \_\_\_\_\_