



Informed Consent for Acupuncture Treatment

I hereby request and consent to the performance of acupuncture treatments 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 acupuncturist who now or in the future treat me.

I understand that the methods of treatment may include, but are not limited to, acupuncture and Chinese herbal medicine. The chinese herbs used are prescribed for the relief of many symptoms however, each individual responds differently to them and may result in unpleasant or negative side effects such as digestive upset, bad taste in mouth, rashes, hives, or tingling of the tongue.

I have been informed that acupuncture is a generally safe method of treatment and uses fine, sterile, disposable needles inserted into various acupuncture points on the body, but may have some side effects that include bruising, bleeding, numbness, tingling near the needle sites that may last a few days and, dizziness or fainting. I also have been informed that sensations associated with acupuncture include a brief prick, a traveling sensation, a dull ache, a sharp sensation, flushing, general tiredness or heaviness. Unusual risks of acupuncture include infection, spontaneous miscarriage, damage to nerves, or organ puncture which could include lung puncture (pneumothorax).

I understand that I should not make any significant changes to body positioning during treatment once needles are inserted. If needles are in place and I make any large movements or lay on an inserted needle I am responsible for the potential side effects. In event of an emergency during treatment I am encouraged to remove accessible needles or wait for help.

I understand the risks and possible side effects as they have been explained to me and understand that this document may not include other side effects and risks that may occur. I do not expect the clinical staff to be able to anticipate and explain all the possible risks and side effects of the treatment and I will rely on the clinical staff to practice good judgement during the treatment. I understand that results are not guaranteed.

I understand that clinical and administrative staff of Frontier Chiropractic may review my personal health information, but all my records will be kept confidential as stated in Frontier Chiropractic HIPAA Notice of Privacy Practices.

By signing below, I show that I have read, or have had read to me, the above consent to treatment and have been told the risks and benefits of acupuncture and other procedures, and have had the opportunity to ask questions.

Printed Name: _____

Patient Signature: _____

Date: _____