**Patient Information and Consent Form**

Please read this information carefully and ask your doctor to explain anything you do not understand

Acupuncture is a medical treatment in which fine needles are inserted into specific points on the body to relieve pain and help treat medical disorders.

**Single use, sterile, disposable needles are used for treatment**

Acupuncture is generally considered a safe procedure but as with all procedures/treatments there are potential side effects or risks. **Potential risks of treatment include but are not limited to**

* **Minor bleeding or bruising**
* **Lightheadedness or fainting**
* **Drowsiness after a treatment. If your experience this response you should not drive**
* **Potential temporary worsening of symptoms after a treatment. Please call with any concerns or questions**

**Other, rarer risks include but are not limited to infection, nerve injury, broken needle, significant bleeding, and puncture of a lung or other organ.**

In addition to your medical history please advise your doctor

* Medications you are taking
* Any history of fainting, seizure or unusual reaction to medical treatment
* Of implanted devices such as pacemaker
* Of any previous surgeries including joint replacement, spinal surgery
* Of any history of bleeding disorder or if you take blood thinners
* Of any cardiac problems
* Of any reason you may be at increased risk of infection or immunocompromised

**Statement of Consent**

**In signing this form I have read and understand the above information. I consent to having acupuncture treatment acknowledging that no guarantee of results has been make to me. I understand I can refuse treatment at any time**

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In event of an emergency I give consent to please contact:

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_