Informed Consent to Treatment

I, _____, hereby request and consent to treatment by acupuncture and/or other procedures within the scope of the practice of acupuncture. Methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, *Gua Sha*, herbal therapy, bodywork, Reiki and medical *Qigong*. I am hereby informed that the aforementioned treatment methods are all generally safe but that there may be some side effects or risks, as follows:

- Acupuncture may potentially cause temporary bruising, swelling, bleeding, numbness and tingling, or soreness at the site of needling. Unlikely risks of acupuncture include lung puncture (pneumothorax), nerve damage, organ puncture, and infection. Potential risks of moxibustion include blistering, burns, and scarring. Common side effect of cupping and *Gua Sha* are temporary bruising and redness lasting up to 10 days.

- The herbal and nutritional supplements (which may be from plant, animal, or mineral sources) recommended to me are generally safe in the traditionally recommended doses. Possible side effects of herbs include nausea, gas, stomach ache, diarrhea, and headache. Unusual side effects of herbs include vomiting, rashes, hives, and tingling of the tongue. I understand I must stop taking any herbs and notify my acupuncturist if I experience any discomfort or adverse reaction.

- I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant as certain acupuncture points and herbs are contraindicated during pregnancy and could induce miscarriage.

- I understand that I can discuss risks and benefits further before signing if I so choose, although I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on my practitioner to exercise her judgment in my best interest during the course of treatment, based upon the facts then known.

- I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

- I understand that my practitioner will keep all of my records confidential.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, healthcare operations received, incurred, or carried out by my practitioner:	Current Date
Printed Name of Patient or Responsible Party	
Signature of Patient or Responsible Party	