



INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other complementary medicine procedures including various modes of physio-therapy on me (or patient named below, for whom I am legally responsible) by Molly DeFazio and/or Donna Turner, EAMP.

I understand that methods or treatment may include, but are not limited to: acupuncture, moxibustion, cupping, moving cupping, electrical stimulation, Tui-Na (Chinese Massage), Chinese or Western herbal medicine, supplement recommendations, and nutritional counseling.

Acupuncture attempts to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infection and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal upset or allergic reactions to the herbs, I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications. I wish to rely on the acupuncturist to exercise judgment during the course of the procedure, which the acupuncturist feels at the time, based upon the facts then known, is in my best interests.

I understand the clinical 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 consent. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content.

I understand my patient records and patient information will be kept confidential and shared only when necessary to provide care and services, or by my authorization, or when required or permitted by law.

By signing below, I agree to the above-named procedures. 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

Signature of Patient or Legal Representative

Date