ACUPUNCTURE INFORMED CONSENT TO TREAT

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 the patient named below for whom I am legally responsible) by the acupuncturist(s) who now or in the future treat me.

I understand that methods of treatment may include, but are not limited to, acupuncture, Chinese herbal medicine, electrical stimulation (e-stim), Tui Na (Chinese massage), cupping, Gua Sha, moxibustion, and nutritional/lifestyle counseling. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness, tingling, or bleeding near the needling sites that may last for a few days. Dizziness or fainting are also possible side effects. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the center uses sterile, disposable needles and follows a clean needle technique and maintains a clean and safe environment. There may be bruising after Gua Sha or cupping. Moxibustion and the use of heat therapies may in rare instances cause burning or scarring.

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, animal and mineral 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 effect of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will immediately notify a staff member who is caring for me if these side effects occur, or if I become pregnant.

I do not expect the YMCA of the North staff to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on clinical staff to exercise judgment during the course of treatment, which the clinical staff thinks at the time, based upon the facts then known, and is in my best interest. I understand that results are not guaranteed.

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

I am aware that the George Wellbeing is connected with the YMCA of the North. Noise and/or disruptions from above and below fitness facilities may be part of my experience, but will not interfere with treatment.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the possible 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.

Client Name (please print) : _____

Client Signature or Parent/Guardian Signature : _____

Parent/Guardian Name (please print) : _____ Date: _____

Revised May, 2022 | FO_HL Acupuncture Informed Consent