Alternative Approach Acupuncture & Wellness
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ACUPUNCTURE AND MASSAGE THERAPY INFORMED CONSENT TO TREAT

I consent to acupuncture and massage therapy treatments and other procedures associated with in the scope of acupuncture and massage therapy on me (or on the patient named below, for whom I am responsible) by ________

I understand that methods of treatment may include but are not limited to; acupuncture, moxibustion, cupping, gua-sha, electrical stimulation, Tui Na (Chinese Massage), Massage Therapy, Chinese herbs, nutritional counseling, and cryotherapy.

I have been informed that acupuncture is generally a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. Bruising is a common side effect of cupping.

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) which may be recommended are traditionally considered safe, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects from taking herbs are nausea, gas, stomachache, vomiting, diarrhea, rashes, hives and tingling of the tongue. I understand that the herbs need to be prepared and the tea consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant taste or smell. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I will notify the acupuncturist if I am, or if I become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the information I provide to them, is in my best interests.

I understand that my records will be kept confidential and will not be released to any party without my written consent.

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 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.

Patients Signature: ________________________ Date:___________________

Patient Advisory to Consult a Physician

Alternative Approach Acupuncture & Wellness and their affiliates is committed to your health and well-being. While Oriental medicine has a great deal to offer as health care system, it cannot totally replace the resources available through biomedical physicians. Consequently, it is recommended that you consult a physician regarding any condition or conditions for which you are seeking acupuncture treatment. To comply with Article 160, Section 8211.1 (b) of NYS Education law, it is requested that you read and sign the following statement: I undersigned, do affirm that ____ has been advised by Alternative Approach Acupuncture & Wellness and their affiliates, to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

Patient Signature: _________________________________ Date: _________________