INFORMED CONSENT FOR ACUPUNCTURE CARE

Acupuncture

Patient: _____ **DOB:** _____

Date: _____ **Chart #:** _____

Nature of care. Acupuncture care may include thin, sterile needles and adjunctive therapies.

Available services/techniques: ☐ Acupuncture ☐ Electroacupuncture ☐ Infrared heat/moxibustion ☐ Cupping ☐ Gua sha ☐ Tui na/manual therapy ☐ Therapeutic exercise ☐ Other: _____

Possible benefits. Possible benefits include reduction of pain or other symptoms, improved mobility or function, support for recovery, and relaxation. Results vary, and no outcome is guaranteed.

Risks and side effects. Common effects may include soreness, minor bleeding, bruising or temporary discoloration, fatigue, lightheadedness, fainting, or a temporary increase in symptoms. Infection is uncommon but possible. Rare complications include a retained or broken needle; injury to a nerve, blood vessel, or internal organ; and pneumothorax (collapsed lung). Electroacupuncture may cause discomfort, skin irritation, muscle contraction, or interference with an implanted electrical device. Heat or moxibustion may cause burns, fire, or smoke sensitivity. Acupuncture, cupping, gua sha, and manual therapy may cause soreness, bruising, marks, skin irritation, or blistering.

Important disclosures. I will tell the practitioner before treatment if I may be pregnant; use blood thinners; have a bleeding disorder, pacemaker or implanted electrical device, seizure or fainting history, immune suppression, skin infection, recent surgery, or sensitivity to needles, heat, smoke, adhesives, latex, or topical products.

Alternatives. Reasonable alternatives may include no treatment or watchful waiting, self-care, medical evaluation, physical therapy, medication or pain-management care, chiropractic or massage therapy, or surgery when appropriate. If treatment is declined or delayed, symptoms may remain or worsen, although the course cannot be predicted.

Patient-specific concerns or additional risks discussed:

_____

_____

Consent and acknowledgment. I have read this form, or it has been read and explained to me in a language I understand. The practitioner has explained the nature and purpose of the selected care, material risks, expected benefits, reasonable alternatives, and any patient-specific concerns. I have had the opportunity to ask questions and received satisfactory answers. I consent to the selected services during this course of care unless I revoke consent. I may decline any procedure or stop treatment at any time. A new discussion and consent will occur if the treatment plan or material risks substantially change. The practitioner does not guarantee results.

Patient/Representative Signature: _____ **Date:** _____

Relationship (if applicable): _____ **Interpreter/Language:** _____

LAc Name: _____ **Interpreter Signature:** _____

LAc Signature: _____ **Date:** _____