Informed Consent

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 above, for whom I am legally responsible).

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping/gua-sha, electrical stimulation, Tui-Na (therapeutic massage), herbal medicine and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites, that may last a few days, and dizziness and fainting. Bruising is a common side effect of cupping/gua-sha. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture. Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. 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. I will notify the acupuncturist if I am or become pregnant. I will also immediately notify the acupuncturist if there are any unpleasant effects associated with the consumption of the herbs.
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 the 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 conditions for which I seek treatment.

Patient Name (Print)_____Date

Patient Signature _____ Date

_____Date
(or Patient Representative—indicate relationship if signing for patient)

Office Signature _____ Date

Desiree Sterling, L.Ac.