

INFORMED CONSENT FORM

I hereby request and consent to participate in acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below.

I understand that methods of treatment may include, but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, tui-na or shiatsu (oriental massage), Oriental herbal medicine, and nutritional counseling. I am aware that acupuncture means the insertion of disposable fileform needles into the body. I understand these needles may remain in the body for a period of approximately 20 to 30 minutes. I understand that acupuncture can be contraindicated under the following conditions: pregnancy, during a period of extreme emotional stress, or when exhausted, weak or famished. I further understand that when performed under the above, mentioned conditions, fainting, vomiting or other reactions may occur.

I have been informed that acupuncture is a generally 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 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). Infections another possible risk, although sterile disposable needles are used and a clean environment is maintained. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

The herbs and nutritional supplements that may be recommended are traditional considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. Some possible side effects of taking herbs are: nausea, gas, stomachache, vomiting, diarrhea, rashes, hives, and tingling of the tongue. I understand that some herbs may be inappropriate during pregnancy. I will notify the acupuncturist named below if I am or become pregnant. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify the acupuncturist named below of any unanticipated or unpleasant effects associated with the consumption of the herbs.

By voluntarily signing below, I show 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 to any future condition (s) for which I seek treatment.

I am in good health with the following exceptions: _____

Patient Signature _____

(or patient representative)

(Indicate relationship if signing for patient)

Print name _____ Date _____

Theresa Gilmore, A.P.