



Acupuncture Consent Form (2021.1)

Acupuncture Consent Form

*I hereby voluntarily consent to receive acupuncture and acupuncture treatment for my present and future health conditions.

*The procedure, risks, alternatives and aftercare for acupuncture treatment have been explained to my satisfaction.

*I understand and accept the risks of acupuncture include bruising, bleeding, a mild aching, soreness, numbness or tingling at the site, dizziness, fainting and a temporary exacerbation of symptoms, including the extremely rare risks of acupuncture (extremely low incidence when treatment performed by a licensed acupuncturist) including infection, nerve damage, organ puncture and spontaneous miscarriage.

*I understand that this document describes the major risks of treatment and that providers are not able to anticipate and explain all possible complications.

*I understand the possible risks and complications involved that have been listed here.

*I agree to notify my provider of any bleeding disorders, drug therapies or recreational drug use, pregnancy/breast-feeding status, any symptoms that develop during or after treatment and any additional questions that may arise during treatment.

*I consent to receive treatment that involves the above procedures.

*I understand that results are not guaranteed.

*I understand that I have the right to refuse or discontinue treatment at any time. I understand that this refusal may affect the expected results.

Patient Name: *

Date of Birth: *

PATIENT OR PARENT/GUARDIAN

SIGNATURE: *

Date: *
