

Acupuncture Consent form
Center for Complementary Medicine Inc.
Lyn Swirda Lic.Ac., M.Ac., Dipl.Ac.

I hereby request and consent to the performance of acupuncture treatments and other Oriental medicine procedures on me (or on the patient named below, for which I am legally responsible) by the below name licensed acupuncturist. _____ (initials)

I understand that methods or treatments may include but are not limited to acupuncture, moxibustion, cupping, auriculotherapy (ear acupuncture), bloodletting, electrical stimulation, Tui Na (Chinese massage), Gua Sha, Chinese or Western herbal medicine, and nutritional counseling. _____ (initials)

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. I understand the same herbs may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. If I experience any gastro-intestinal reactions to the herbs I will inform the acupuncturist *immediately*. _____ (initials)

I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. 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. _____ (initials)

I understand it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records for the reasons listed above. _____ (initials)

I agree to pay the full charge for any missed or forgotten appointments without 24-hour notice of cancellation. _____ (initials)

I agree to pay all charges incurred for services rendered, including acupuncture treatment, herbal medicine, supplements, homeopathic remedies, moxibustion supplies, returned check fees, educational courses, books and materials. _____ (initials)

Name of Licensed Acupuncturist: _____

Signature of patient or legal representative _____

Date _____