Seasons of Balance Family Acupuncture, LLC

Informed Consent for Acupuncture Treatment

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 person named below, for whom I am legally responsible) by Vanessa Tippett L.Ac.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Japanese handwork, and nutritional suggestions. I have been informed that acupuncture is a generally safe method of treatment, but there are some risks. These include, but are not limited to, bruising of the skin, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is common with cupping and there is a risk of burns and/or scarring. Unusual risks of acupuncture include nerve damage, and organ puncture including pneumothorax. I will notify the practitioner who is caring for me if I am or become pregnant. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The risk of infection is small when all needles are sterile and disposable, and the treatment environment is clean and safe, as is the policy within this clinic.

I understand that all moxibustion includes the application of heat to acupuncture points, and other areas of the body, by manipulating a burning herb, in various ways, to allow the heat to warm and penetrate the skin. I understand there are some risks to treatment with moxibustion, including but not limited to, a risk of burn and/or scarring. The risk of infection exists if burning occurs.

I have had an opportunity to discuss with the practitioner the nature and purpose of acupuncture and Traditional Chinese Medicine. I understand that results are not guaranteed.

I do not expect the practitioner to be able to anticipate and explain all risks and complications. I wish to rely on the practitioner to exercise judgment to treat according to my best interest, based upon the facts then known, during the course of the procedure.

I understand the practitioner may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that I have the choice to accept or reject the proposed diagnostic procedure or treatment, or any part of it, before or during the diagnosis or treatment.

I understand that the practitioner is not providing Western (allopathic) medical care, and that I should look to my Western primary care physician for those services and for routine check-ups.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

Patient name _____

Patient Signature _____ Date _____

Consent to treat a minor child: I hereby authorize Seasons of Balance Family Acupuncture to administer treatment to my child.

Name of Child _____

Parent Signature _____ Date _____

___I have discussed the above information with the patient, including risks, benefits and alternatives to the proposed treatment.

Practitioner Signature _____ Date _____