Seasons of Balance Family Acupuncture, LLC
8650 US Hwy 51 N Minocqua, WI 54548

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 the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. 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. It is expected that patients are under the care of a primary care physician or medical specialist; that pregnant patients are being managed by an appropriate healthcare professional; and that patients seeking adjunctive cancer support are under the care of an oncologist.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Japanese handwork, Chinese herbal medicine, 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, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is common with cupping. 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. Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. 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 a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. 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 have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs. Some possible side effects of taking herbs are: nausea, gas, stomachache, vomiting, liver or kidney damage, headache, diarrhea, rashes, hives, and tingling of the tongue.

While 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 that results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff 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 there are treatment options available for my condition other than acupuncture procedures. I further understand that I have a right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm that 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 agree with the current or future recommendations for care. 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 (print): _____ Date: _____

Patient (or guardian) Signature: _____ Date: _____

Acupuncturist: _____ Signature: _____ Date: _____