



Acupuncture Informed Consent to Treat

I hereby request and voluntarily consent to be treated with acupuncture and other procedures/modalities within the scope of practice of acupuncture and Oriental medicine by Jennifer Munson, LAc, MSOM 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 Jennifer, whether signatories to this form or not. I understand that acupuncturists practicing in the state of Colorado are not primary care providers and that regular primary care by a licensed physician is an important choice that is recommended by this clinic's practitioner.

I understand that methods of treatment may include, but are not limited to: acupuncture, moxibustion, cupping, gua sha, electrical stimulation, Tui-Na, Shiatsu, Chinese herbal medicine, and nutrition and lifestyle counseling. I understand that I may ask my practitioner for a more detailed explanation of any of these treatment methods at any time and that I may refuse any of the treatment modalities.

Acupuncture: I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, minor bleeding, pain or discomfort, numbness or tingling near the needling sites that may last a few days, dizziness or fainting, or aggravation of symptoms existing prior to treatment. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk although the clinic uses sterile disposable needles and maintains a clean and safe environment.

Moxibustion and heat lamps: Burns and/or scarring are potential risks of moxibustion or when treatment involves the use of heat lamps.

Cupping/Gua Sha: Local soreness and bruising which may last up to a week are common side effects with cupping and gua sha. Burns are also a possible side effect when using fire cupping.

Shiatsu/Tui Na: Soreness, achiness, or aggravation of symptoms existing prior to treatment are possible side effects of Oriental bodywork.

Electro-Acupuncture: Side effects of electrical stimulation may include electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment.

Chinese Herbs: I understand that 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 the herbs may need to be prepared according to specific instructions and all herbal prescriptions should be used according to the instructions provided orally and in writing. The herbs may have an unpleasant taste or smell. I understand that some herbs may be inappropriate during pregnancy and I will notify my practitioner if I am, or become, pregnant. Some possible side effects of taking herbs are nausea, vomiting, gas, diarrhea, stomachache, headache, rashes, hives, and tingling of the tongue. I will immediately notify my practitioner of any unanticipated or unpleasant effects associated with the consumption or use of the herbs.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which they think at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed and I may choose to stop treatment at any time.

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.

By voluntarily signing below, I show that I have carefully read (or had read to me) the above consent to treatment, have been informed about the risks and benefits of acupuncture and other treatment modalities, 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 for any future condition(s) for which I seek treatment.

PATIENT NAME (please print):

PATIENT SIGNATURE:

DATE: