North Suburban Chiropractic and Acupuncture

Informed Consent for Acupuncture Treatments

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, massage, gua sha, and nutritional counseling.

I, understand that acupuncture, moxibustion, electrical stimulation, cupping and pricking are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last for a few days. Unusual risks of acupuncture include dizziness, fainting or nerve damage. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential risks of moxibustion therapy are burns, blistering, or scarring. Temporary bruising and/or redness lasting a few days are a common side effect of cupping and gua sha. I fully understand that there is no implied or stated guarantee of success of effectiveness of a specific treatment or series of treatment.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points that could be harmful during pregnancy. Otherwise, Chinese Medicine treatments can be very beneficial during pregnancy and the birthing process.

I understand that nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of nutritional supplements taken without my practitioner's recommendation may be toxic or inappropriate. Some possible side effects of nutritional supplements are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, and hives. I understand that I must stop taking any nutritional supplements and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.

I understand that my acupuncturist may review my medical records and lab reports, but all my records will be kept confidential. If it becomes necessary to share my health information, this will be handled in accordance with stipulations detailed in the Notice of Privacy Practices document that has been provided to me, and of which I have acknowledged receipt.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However I do not except my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise their judgement in my best interest during the course of treatment, based upon the facts then known.

I recognize that scheduling an appointment involves the reservation of time specifically for me, and that consequently, a minimum of 24 hours' notice is required to reschedule or cancel an appointment. Unless otherwise agreed to in advance, the full fee will be charged for sessions missed without such advance notification. I understand that most insurance companies do not reimburse for missed sessions.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment; payment and healthcare operations received, incurred or carried out at this practice.

Signature of patient or representative Date