GREENACRE
acupuncture

Patient Introduction & Informed Consent

Acupuncture is a healing therapy that involves inserting fine needles into specific points along meridians on the body. It can reestablish and unblock the flow of Qi/energy. In addition to the use of needles, the scope of acupuncture includes use of electrical devices to stimulate acupuncture points, acupressure, cupping, moxabustion, and/or gua sha.

While acupuncture has proven to be highly effective in correcting conditions and maintaining overall well being, practitioners are required to advise patients that there may be some risks. Although practitioners cannot anticipate all the possible side effects and complications that may arise with each individual case, you should be aware that the following side effects could occur. If there are particular risks that apply in your case, your practitioner will discuss these with you.

Possible side effects may include: drowsiness, feeling faint, minor bleeding/bruising, some pain following treatment in the insertion area, infection, and broken needle. In less than 3% of patients, symptoms may become worse for 1-2 days following treatment, before they improve. This is usually a good sign. Please contact your acupuncturist if worsening of symptoms continues for more than 2 days.

If you are pregnant, are taking anti-coagulants (blood thinners) or any other medication, have a bleeding disorder, have a pacemaker or other metal/electrical implants, have damaged heart valves or any other particular risk of infection, have a heart condition, diabetes, circulatory problems, blood clots, cancer/malignancies, or bone disorders please make this information known prior to your treatment.

I confirm that I have read and understood the above information, and I consent to having treatments and procedures from the acupuncturist named below. I have read the possible risks of treatment outlined above, but do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. I also understand that I can refuse treatment at any time.

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By voluntarily signing below I show that I have read this consent to treatment, have been told about the risks and benefits of treatments provided, know that there are no guaranteed results, 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 further conditions for which I seek treatment.

Date: _____

Name: _____

Signature: _____

Release of Information

All information provided herein is true and correct. I hereby consent to treatment. I give permission to my provider and staff to release information, verbal and written, contained in my medical record and other related information to related health care providers, assignees, and/or beneficiaries and other related persons. I have read and understand this release.

X: _____ Date: _____

Appointment Cancellation Policy

I understand that 24 hours notice is required when cancelling an appointment. I also understand that the full cost of the visit will be charged if I do not cancel 24 hours prior to the appointment.

X: _____ Date: _____