Informed Consent to Treat

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist(s) at Community Supported Acupuncture who now or in the future treat me while employed by, working or associated with or serving as back-up for Community Supported Acupuncture, 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 a technique using sterile, single-use stainless steel needles inserted at specific points in the body. Only disposable needles are used in this clinic. Although rare, minor side effects may result from acupuncture. These may include minor bruising, very minor bleeding, and temporary soreness at the site of needle insertion. Momentary euphoria or light-headedness may occur after acupuncture treatment. These events are uncommon and of short duration.

Electrical stimulation of the acupuncture needles involves using a small, battery-powered stimulator attached by wires to the acupuncture needles. A slight throbbing or tingling sensation may be felt during and for a few hours after the use of this stimulator.

Cupping uses round vacuum cups over a large muscular area to enhance blood circulation to the designated area. This method may produce a deep redness, discoloration and on rare occasions, a minor blister which may persist for up to several days. These marks will resolve on their own and are not indications of complications or injury.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I give my permission and consent to treatment.

Print Name:_____ Signature _____ Date _____

Signature of patient representative _____ Date _____

FINANCIAL AGREEMENT

Cancellation/no show policy:

Please be advised that we need a 24-hour notice of cancellation, otherwise you will be charged $40.00.

Financial responsibility:

I understand that I am responsible for payment for all costs of treatment.

Patient's Signature: _____ Date: _____

Parent or Guardian's Signature: _____Date_____