*PATIENT’S NAME:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **MedVed Integrative Medicine and Acupuncture Clinic**

 **10951 SORRENTO VALLEY RD 1-d san diego ca 92121 phone:** 619-354-0455

 **Acupuncture • auricular acupuncture • Cuppung/ massage • REIKI • electric acupuncture** **• herbs** **• IASTM • TUI NA**

 **INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE**

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures on me (or on the patient named below, for whom I am legally responsible) by a licensed acupuncturist.

  Initial here\_\_\_\_\_\_.

I understand the methods of treatment may include but are not limited to: acupuncture, moxibustion, cupping, electrical stimulation, Tui Na (Chinese Massage), auricular acupuncture and Chinese herbal medicine.

  Initial here\_\_\_\_\_\_.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting.

  Initial here\_\_\_\_\_\_.

I understand that I should not move while the needles are being inserted, retained, or removed.

I understand that I should not reinsert needles on my own, readjust or touch any medical equipment during the treatment.

 Initial here\_\_\_\_\_\_.

I understand that I should not drink alcohol 2 hours before and after the treatment to avoid possible complications. I been informed that alcohol consumption together with herbal supplements can lead to serious health problems.

  Initial here\_\_\_\_\_\_.

Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment.

 *PATIENT’S NAME:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Burns and/or scarring are a potential risk of moxibustion.

The cupping process may leave minor red marks on skin known as petechiae. This marks will dissipate within a couple of hours or days and have no permanent effect.

  Initial here\_\_\_\_\_\_.

I understand that while this document describes the major risks of treatment other side effects and risks may occur.

  Initial here\_\_\_\_\_\_.

The herbs and nutritional supplements (which are from plant, mineral, and animal 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. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I understand that I will not share my Herbal supplements with anybody else.

  Initial here\_\_\_\_\_\_.

I will notify the acupuncturist who is caring for me if I am or become pregnant.

  Initial here\_\_\_\_\_\_.

I will notify the acupuncturist about recent change in my health condition, new Rx drugs or supplements intake.

  Initial here\_\_\_\_\_\_.

I understand that the risk of infection is negligible when all needles are sterile.

  Initial here\_\_\_\_\_\_.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my consent. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content.

 Initial here\_\_\_\_\_\_.

I understand my patient records and patient information will be kept confidential and shared only when necessary to provide care and services, or by my authorization, or when required or permitted by law.

 Initial here\_\_\_\_\_\_.

By voluntarily signing below I show that I have read, or have had read to me, this 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 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’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Signed: \_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_

 To be completed by the patient’s representative if the patient is a minor or is physically or legally incapacitated:

Print Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Patient Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship or Authority of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Acupuncturist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Acupuncturist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_