INFORMED CONSENT TO ACUPUNCTURE TREATMENT

I consent to acupuncture treatments and other procedures associated with the practice of traditional Chinese medicine provided by Re-Balance Acupuncture / Dr. Erica Hsu, DACM, LAc., PLLC. I have discussed the nature and purpose of my treatment with the member of the clinical staff hereof and understand the risks and benefits of such treatment, and consent to such treatment. I understand that the profession of acupuncture is the treating, by means of mechanical, thermal or electrical stimulation affected by the insertion of needles or by the application of heat, pressure or electrical stimulation at a point or combination of points on the surface of the body predetermined on the basis of the theory of the physiological interrelationship of body organs with an associated point or combination of points for diseases, disorders and dysfunctions of the body for the purpose of achieving a therapeutic or prophylactic effect. The profession of acupuncture includes recommendation of dietary supplements and natural products including, but not limited to, the recommendation of diet, herbs and other natural products, and their preparation in accordance with traditional and modern practices of East Asian (Chinese, Korean or Japanese) medical theory. In addition, I understand that methods of treatment may include, but are not limited to the following: acupuncture, moxibustion, cupping, electrical stimulation, herbal supplementation and Tui Na (Chinese Massage).

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness, soreness or tingling near the treatment sites that may last a few days, and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although this site uses sterile, disposable needles and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. Further, with knowledge of such risks and potential side effects, I wish to and consent to receive such treatment.

I agree and will notify the clinical staff member who is caring for me if I am pregnant. In addition, I agree and will notify the clinical staff member who is treating me of any underlying medical conditions for which I am seeking medical treatment. I further agree to consult a medical physician regarding the condition or conditions for which I am seeking acupuncture treatment. I further understand that there are limitations to acupuncture treatment and related procedures and that such treatment is not a substitute for medical care with allopathic or osteopathic physicians. I understand and acknowledge that the clinical staff may not be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgement during the course of treatment which the clinical staff thinks at the time, based upon the facts known to them, is in my best interests.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been informed of the risk and benefits of acupuncture treatment and related procedures, have had an opportunity to ask questions and receive answers regarding such risks and benefits of treatment, and knowingly, willingly, and intelligently consent to such treatment.

Signature of Patient or Representative_____ Date: _____

Print Name of Patient Representative (if applicable)_____ Date: _____

This office is HIPAA Compliant. This and all patient information is kept confidential and cannot be released without your written consent.