ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I lam legally responsible) by the acupuncturist, David R. Johnson.

I understand that methods of treatment may include, but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, Chinese herbal medicine, and nutritional counseling. I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

I understand that acupuncture may be inappropriate during pregnancy, therefore I will inform the acupuncturist if I become pregnant. For the case of absolute safety, I understand that acupuncture will not be performed on me if I am pregnant without written consent. I will immediately notify David R. Johnson, who is caring for me if I am or become pregnant.

I do not expect the David Johnson to able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the his expertise to exercise judgment during the course of treatment which is based upon the facts then known is in my past interest. I understand that results are not guaranteed.

I understand that David Johnson may keep and review any records pertaining to appointment days, times and charges. Only the acupuncturist may keep and reviewDepression/Anxiety/Mood Issues patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.
By voluntarily signing below, I show that I have read, or have had read to me, the above 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 SIGNATURE _____Date _____

Patient Name (Please print) _____

(Or Patient representative – Indicate relationship if signing for patient)_____

David Johnson, C. Ac., L. Ac. _____ Date _____