COMMUNITY ACUPUNCTURE INFORMED CONSENT TO TREAT

I give my consent to receive acupuncture treatment (for myself or for the patient named below, for whom I am legally responsible) performed by the acupuncturists at Maplebrook Acupuncture Clinic (MBC). This treatment may include acupuncture and or Chinese herbal medicine.

I understand that acupuncture involves the insertion of fine needles at specific points on the body. Acupuncture is generally considered to be a very safe method of treatment, but I understand that side effects can occur. Possible side effects of acupuncture include bruising, bleeding, numbness or tingling near the needling sites that may last a few days, dizziness, and fainting. Unusual risks of acupuncture include infection, spontaneous miscarriage, seizures, nerve damage, and organ puncture, including lung puncture (pneumothorax). To minimize the risk of infection, MBC uses sterile, single use acupuncture needles and maintains a clean and safe environment.

If an acupuncturist recommends it, I may choose to use Chinese herbal medicine. Chinese herbal medicine is generally considered to be very safe, but I understand that herb should be taken as directed by the acupuncturist. Some may be considered toxic in large doses or inappropriate during certain conditions, such as pregnancy. I will immediately notify an acupuncturist if I experience any unpleasant side effects while taking herbs. Possible side effects of Chinese herbal medicine, include nausea, gas, stomachache, vomiting, diarrhea, rashes, hives, and tingling of the tongue.

I understand that MBC provides acupuncture in a community setting. The purpose of this setting is to allow as many people as possible to access treatment and to decide for themselves how they wish to use acupuncture to manage their health. Common side effects of acupuncture treatment in a community room include deep relaxation, falling asleep, and snoring. I understand that if I need to be woken up at a certain time, I will let the reception staff and the acupuncturist know. I understand that I might be too relaxed to drive immediately after treatment. If other people's snoring bothers me; I understand that I need to bring earplugs or headphones. I understand that at times, someone else might be sitting in my favorite recliner. I understand that community acupuncture involves actual community with a wide variety of people, and may at time require some flexibility, patience, or understanding from me.

I understand that acupuncture needles are very small; a different acupuncturist may remove the needles than the one who inserted them; and so I may need to help my acupuncturist locate all of the needles at the end of my treatment and before I leave the clinic**. I understand that I am not to remove my own needles and doing so may result in termination as a patient at MBC.** I understand that MBC needs to treat a high volume of patients in order to keep its prices as low as they are, and I am willing to participate in my own treatment process.

I understand that while this form describes major risks of treatment, other side effects and complications may occur. I do not expect the acupuncturists to be able to anticipate or explain all possible risks and complications of treatment. I understand that results are not guaranteed.

I understand that acupuncture is a process, and that results will be best when I receive acupuncture regularly and as frequently as my acupuncturist recommends. I will ask my acupuncturist if I have questions about my treatment or about the risks and benefits of acupuncture. I will notify an acupuncturist if I am or become pregnant.

I understand that my records will be kept confidential and will not be released without my written consent. Clinical and administrative staff may review my records as needed.

I have read this information (or had it read to me), and I have had an opportunity to ask questions. By singing below I voluntarily give consent to receive acupuncture as treatment for my present condition and for any future conditions.

Name of Patient (please print) _____

Signature of Patient or Patient Representative: _____

Acupuncturist Name: _____ **Date:** ___/___/___