Information About Acupuncture Treatment

Acupuncture is a health care modality that involves the stimulation of specific points on the body. It has the effect of normalizing physiological function, modifying the perception of pain, and treating certain diseases or dysfunctions of the body. The stimulation may be produced by needles, heat, manual pressure, electrical currents, or other means, but most frequently by needling. This clinic uses **single-use, sterilized, disposable needles** for each acupuncture treatment.

Acupuncture is considered a very safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that lasts from a few minutes to a few days. There have been rare instances reported in which a patient fainted, developed a scar or infection, or sustained a pneumothorax (air in the chest cavity that could cause a collapsed lung). This clinic takes many precautions to minimize the risk of adverse events.

Herbs and nutritional supplements may be prescribed and are considered safe in the practice of Chinese Medicine. Some herbs or supplements have an unpleasant taste, and some are contraindicated during pregnancy or for patients taking anticoagulants such as Warfarin (Coumadin). Discontinue taking and notify our office immediately if you experience nausea, gas, stomachache vomiting, headache, diarrhea, rashes, or tingling of the tongue. These are uncommon side effects associated with some products.

Cupping involves a localized suction produced by heating a small glass cup. Local bruising from the suction is likely, but bruises are rarely painful or uncomfortable. They typically resolve in 7-10 days or less.

Consent for Acupuncture Treatment

I have read and understand the benefits and possible risks of treatment by acupuncture and use of Chinese herbal medicine to me. I understand that, as with all health care, no guarantee of results can be made. My questions have been answered and I wish to proceed.

Signature: _____ Date:

_____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient:

_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT UPON REQUEST.

Consent for Use and Disclosure of Health Information

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care

operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of privacy practices, including any revisions of our Notice, at any time from our website at www.asiantherapeutics.com.

RIGHT TO REVOKE: You will have the right to revoke this Consent at any time by giving us written notice of you revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have been informed of, and given the right to review and received a copy of your *Notice of Privacy Practices.* I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient:

_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT UPON REQUEST.