



## Informed Consent Form

### **Voluntary Consent**

I hereby voluntarily request and consent to be treated, or give permission for my child/ward to be treated, with acupuncture; electro-acupuncture; acupressure and other techniques based on Traditional Asian Medicine. I understand I may be given recommendations on diet, lifestyle and nutritional or herbal supplements and it is my decision whether or not to follow these recommendations. The procedures involved in this treatment have been explained to me. I understand I may be treated with the insertion of needles or other non-insertion techniques; electrical stimulation; or touch/palpation.

I have not been guaranteed any success concerning the uses and effects of these treatments. I understand that I am free to discontinue treatment at any time.

### **Possible Side Effects/Healing Reactions**

I understand that these treatments may result in certain side effects, including local bruising; slight bleeding; fainting; temporary pain or discomfort; and temporary aggravation of symptoms existing prior to treatment. Unusual and rare risks of acupuncture include nerve damage, organ puncture, and infection. I have read the information on this page and understand the possible risk involved.

### **Medical Referral**

I understand that I should consult a licensed physician for appropriate medical evaluation and treatment of the conditions for which I am seeking acupuncture treatment. Treatment from this practitioner does not substitute for appropriate medical treatment by a licensed physician. I have been advised that if there is a worsening of my ailment or condition, or if it does not improve within the time estimated by the acupuncturist at the beginning of treatment, or if a new ailment or condition arises, I should again consult a licensed physician. If I am presently under the medical care of a physician, I have been advised to continue all medications and treatments as prescribed until such time as my physician deems it appropriate to reduce or discontinue the medications or treatments. I certify that I have informed MNCA of all known physical, mental, and medical conditions and medications, including possible pregnancy, and that I will notify MNCA of any changes.

### **Infectious Disease/Clean Needle Procedures**

I understand that there is infectious disease carried through the air, through physical contact, and through body fluids. I understand that universally prescribed precautions will be utilized during treatments to guard against the spread of infection, including the use of sterilized, prepackaged disposable needles. Needles that are used for my treatment are used only on me, and are inserted according to clean procedures based on nationally prescribed standards. Needles are disposed of as medical waste immediately after use. I understand that my questions about the safety of any procedure or treatment or the precautions taken by the practitioner are most welcome and will be answered as fully as possible. I understand I have the right to refuse any treatment or procedure. I have read this form carefully. I have felt free to ask any questions, and it has been satisfactorily explained to me.

### **Payment and Cancellation Policies**

Current fees are: Initial visit = \$ 25 - \$ 45 Follow-up visits= \$ 15 - \$ 35

Full payment is expected at the time services are rendered.

A \$30 fee is charged for the first check returned by the bank. If a second check is returned, subsequent payments must be cash.

If you must cancel your appointment, we require a 24 hour notice to avoid a \$ 15 cancellation fee.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date