

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physiotherapy on me (or on the patient named below, for whom I am legally responsible) by Jaclyn Engelsher Certified and Licensed Acupuncturist (KY, IN) and Doctor of Oriental Medicine (NM).

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese Acupressure massage), Chinese herbal medicine, and nutritional counseling.

I have had the opportunity to discuss with the acupuncturist the nature and purpose of acupuncture treatments and other procedures.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. Other side effects may include discomfort, dizziness, or nausea. Cupping may result in bruising that will last a few days. There have been very rare instances of fainting, infections, and scarring. There have been extremely rare instances reported of spontaneous miscarriage, pneumothorax, or organ puncture.

The herbs that may be recommended are traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal upset or allergic reactions to the herbs, I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risk and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interest.

I understand that acupuncturists practicing in the Commonwealth of Kentucky are not performing a medical service as a primary health care provider. I certify that I am currently under the care of a licensed allopathic physician and have agreed to disclose medical information if I have the following conditions: hypertension, cardiac conditions, acute or severe abdominal pain, neurological changes, unexplained weight gain or loss of 15% or greater in the past three months, suspected fracture or dislocation, suspected systemic infection, serious hemorrhagic disorder, acute respiratory distress without previous history, pregnancy, diabetes, and cancer.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my record will be kept confidential and will not be released without my written consent.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to the above named procedures. I submit that I have voluntarily chosen to receive treatment and agree to indemnify and hold harmless the acupuncturist and facility from any claims. I intend this consent form to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.

Name of Patient (please print)

Patient's Representative, if necessary

Patient's Signature

Relationship to Patient

Date Signed