864 Rt 37 West
Toms River, NJ 08755
P. 732-503-4079 F. 732-503-4127

INFORMED CONSENT FOR ACUPUNCTURE

I ___________________________________ freely choose to undergo acupuncture treatments, knowing that there are no guaranteed results, and I am free to stop acupuncture treatment at any time.

I understand that while acupuncture is generally a safe method of treatment, certain adverse effects may result from treatment. These may be, but are not limited to, fainting, some local bruising, puffiness, redness, blood, and temporary pain or discomfort at the site of the needles during or after treatment.

I understand the methods of treatment in the scope of Chinese medicine may include but are not limited to acupuncture, cupping, moxibustion (applying heat to acupuncture points), electro-acupuncture (electric stimulation on the needles), Tui-Na (Chinese massage), Qigong (energetic work), and herbal medicine.

I understand the acupuncturist is not providing Western medical care, and that I should speak with my Primary Care Physician (MD) for those services and routine check-ups.

I have read, or have had read to me, this informed consent and completely understand the risks and benefits of acupuncture treatment and have had an opportunity to ask questions. This consent form covers the patient for the entire course of their treatment plan. It covers my present condition and for any future condition(s) for which I seek acupuncture treatment in this facility.

___________________________________	_______________
Patient Signature	Date
___________________________________	
Patient Printed Name	
___________________________________	_______________
Witness	Date