Patient Advisory to Consult Physician

To comply with Article 160, Section 8211.1(b) of NYS Education law, we request that you read and sign the following statement:
We, the undersigned, do affirm that _____________________________ (patient) has been advised by

________________________________ (Lac.) to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

____ _______________
Patient Signature Date

____ _______________
Licensed Acupuncturist Signature Date

Acupuncture Informed Consent to Treat

I hereby request & consent to the performance of acupuncture treatments & other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below &/or other licensed acupuncturist who now or in the future treat me while employed by, working or associated with or serving as a back-up for the acupuncturist named below, including those working at the clinic or any other office or clinic listed below or any other office or clinic, whether signatories to this form or not.

I understand that the methods of the treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tiu-Na (Chinese massage), Chinese herbal medicine and nutritional counseling. I understand that the herbs may need to be prepared & teas consumed according to the instructions provided orally & in writing.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needle site that may last a few days, & dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture spontaneous miscarriage, nerve damage or organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles & maintains a clean & safe environment. Burns &/or scarring are a risk of both cupping and moxibustion. I understand that while this document describes the major risks of treatment, other side effects may occur. The herbs & nutritional supplements (which are from plant, animal & mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, & tingling of the tongue. I will notify a clinical staff member who is caring for me if I am to become pregnant.

I do not expect the clinical staff to be able to anticipate & explain all possible risks & complications of treatment, & I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand the results are not guaranteed.

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

By voluntarily signing below, I show that I have read or have had read to me, the above consent to treatment, have been told about the risks & benefits of acupuncture & other procedures, & have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

____ ______________________
Patient Signature (or Patient Representative) Date

____ ______________________
Licensed Acupuncturist Signature Date