Inner Balance Acupuncture
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Telephone: 859-595-2164
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ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on myself (or on the patient named below, for whom I am legally responsible) by certified acupuncturists who now or in the future treats me while employed by, working or associated with Robert N. Fueston or any other office or clinic, whether signatories to this form or not.

I understand that methods of 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 and the teas consumed according to instructions provided orally and in writing.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling site that may last a few days. Bruising is a common side effect of cupping. Burns and/or scarring are a potential risk of moxibustion and cupping. The clinic uses sterile disposable needles and maintains a clean and safe environment. I understand while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. 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, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain risks and complications of treatment, and I wish to rely on the clinical staff to exercise appropriate clinical judgement during the course of treatment. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and 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 and benefits of acupuncture and other procedures, and 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 condition(s) for which I seek treatment.

PATIENT SIGNATURE **X** (Date)

(Or Patient Representative) (Indicate relationship if signing for patient)