Doctor's Name ______________________________

Address ______________________________

Phone ______________________________

Date ______________________________

Informed Consent for Oral Acupuncture, Auricular Acupuncture, Homeoacupuncture, Acupuncture, and Neural Therapy

I, ____________________ , hereby authorize Dr. ____________________

and any associate or employees and such assistants as may be selected to treat the condition(s) described below:

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The procedure(s) necessary to treat the condition(s) have been explained to me and I understand the nature of the procedure(s) to be done:

Please read each paragraph and if it is clear and you understand and do not have further questions regarding the statement, then please record your initials by each statement.

Initial ________ I have been informed of possible alternative methods of treatment (if any), including no treatment at all and the risks of non-treatment.

Initial ________ I further understand that this is an elective procedure and other forms of treatment or no treatment are all choices that I have.

Dr. ____________________ has explained to me that there are certain inherent and potential risks in my treatment suggestion(s) or procedure(s), and in this specific instance, such treatment risks include, but are not limited to the following:

Initial ________ A. Possible post-treatment light-headedness and drowsiness.

Initial ________ B. Possible post-treatment tiredness and dizziness.

Initial ________ C. Possible post-treatment bleeding where the skin was punctured.

Initial ________ D. Possible experience of very slight to moderate discomfort and swelling at the point of skin puncture.

Initial ________ E. Possible post-treatment pain at the site of skin puncture.

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Initial ________ F. Possible fainting feeling or fainting.

Initial ________ G. Possible post-treatment skin discoloration at the site of skin puncture.

Initial ________ H. Possible post-treatment numbness or tingling in the area of injection. This may persist for several weeks or months. While this has never happened in our office, this is an extreme, remote possibility.

Initial ________ I. There is evidence indicating local anesthesia in itself, although rare, may produce some parathesia. This is related to the amount of covering, or myelination, about the nerves and has little to do with the mode of technique or administration. Some anesthetics, when administered, could cause an allergic response such as fainting, increased heart rate or blood pressure, and could produce some discoloration at the injection site.

Initial ________ It has been explained to me, and I understand that a perfect result or results are not guaranteed or warranted, and cannot be guaranteed or warranted.

Initial ________ I certify that I read and understand English, and have read and fully understand this consent for acupuncture and neural therapy.

PLEASE ASK DR. ______________________ IF YOU HAVE ANY QUESTIONS CONCERNING THIS CONSENT FORM BEFORE YOU SIGN.

Initial ________ I understand that I am personally responsible for the fees, and that the fees have been fully explained to me. As a courtesy, the basic forms and reports necessary for insurance benefits will be prepared for my use. I understand that my insurance benefits are between me and my insurance company, and that the ultimate responsibility for securing these monies is mine.

Initial ________ I understand that although no guarantees can be given, every effort has been made in the best professional judgement to give me a proper evaluation, proper diagnosis, treatment plan and prognosis.

Signature: ______________________
Patient

Signature: ______________________
Doctor

Signature: ______________________
Parent/Legal Guardian
(if patient is under 18)

Signature: ______________________
Witness
(Professional Staff Member)

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