Acupuncture and Wellness of Charleston, LLC
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ACUPUNCTURE INFORMED CONSENT TO TREAT

*I understand that in the State of South Carolina, "acupuncture" means a form of health care developed from traditional and modern oriental concepts for health care that employs oriental medical techniques, treatment, and adjunctive therapies for the promotion, maintenance and restoration of health and the prevention of disease. I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below.

*I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui 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 the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs or any part of my treatment.

I recognize the potential risks and benefits of these procedures as described. 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 needling sites that may last a few days, dizziness or fainting, discomfort, pain or blistering at the site of the procedure, temporary discoloration of the skin, nausea, loose bowel movements, abdominal cramping, and aggravation of symptoms existing prior to the acupuncture treatment. Bruising is a common side effect of cupping. Unusual risks of acupuncture may include spontaneous miscarriage. I will notify my practitioner immediately if I am pregnant or become pregnant. Other unusual risks include nerve damage and organ puncture including lung puncture (pneumothorax). Infections are another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements that may be 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, diarrhea, rashes, hives, and tingling of the tongue.

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

*I understand that my practitioner may recommend, at any time, that I seek a medical diagnosis and/or treatment from a licensed medical doctor or dentist if she feels that this is in my best interest. I also understand that a visit to a licensed medical doctor or dentist may be recommended if I have not experienced clinical improvement after three consecutive months of treatment for a specific complaint.

***Notice to cancer, epilepsy, and "acquired immune deficiency syndrome" patients:** I understand that if I have cancer, epilepsy or AIDS, I must be under the care of a medical doctor and that I must be following a treatment program prescribed by a medical doctor for these conditions.

***Notice to Pregnant Women**: Labor-stimulating acupuncture points are not used unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment. All female patients must alert the practitioner/acupuncturist if they know or suspect they are pregnant.

***Potential benefits of this type of treatment**: drugless relief of presenting symptoms and improved balance of bodily energies, which may lead to prevention or elimination of the presenting problem and the strengthening of the constitution.

***Potential risks of not having this type of treatment**: condition may worsen or not improve.

***Alternatives to this type of treatment**: traditional/conventional treatment is also available from other practitioners.

*I understand that the clinical staff and administrative staff may review my patient records and lab reports, but all my records will be kept confidential. I understand that a record will be kept of the health services provided to me. I understand that my medical record will be kept for a minimum of ten, but no more than thirteen years after the date of my last treatment. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my practitioner to the best of his/her ability. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Catherine Jones, ND, MS, LAc regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

*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.

_____ _____
Guardian/Personal Representative's Name (PRINT) Patient's Name (PRINT)

_____ _____
Guardian/Personal Representative's Signature Patient's Signature

_____ _____
Relationship/Representative's Authority Date

_____
Date
Acupuncturist: Catherine Jones, ND, MS, LAc

Chief complaint: _____