Advisory and Informed Consent to Treatment

i. Patient Advisory to Consult a Physician

In keeping with Article 160, Section 821 1.1 (b) of NYS Education law, we it is asked that you sign below in order to affirm that you understand the need to consult with your physician regarding the condition for which you are seeking acupuncture treatment. Acupuncture and Traditional Chinese Medicine play an important role as healthcare systems in modern integrative medicine. For integrative medicine to best serve your wellness needs, it is highly recommended that you make use of all tools that are available to you including those available through your biomedical physician.

WE, THE UNDERSIGNED, DO AFFIRM THAT ____ (patient), HAS BEEN ADVISED BY ____ (Licensed Acupuncturist), TO CONSULT A PHYSICIAN REGARDING THE CONDITION/S FOR WHICH SUCH PATIENT SEEKS ACUPUNCTURE TREATMENT.

PATIENT SIGNATURE: ____ DATE: _____________________

ii. Informed Consent to Acupuncture Treatment

By signing below, I do voluntarily consent to acupuncture treatments with practitioners at CNY Community Acupuncture. I understand that the methods of treatment include but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, and bodywork therapies. I have been informed of the possible risks and side effects of the aforementioned treatment modalities. I understand that bruising at needling sites is the most common side-effect of acupuncture treatment. I also understand that tingling or itchiness may occur around needling sites. I agree to inform my practitioner if I feel faint or dizzy during or after treatment. I also understand that, rarely, some serious side-effects of acupuncture treatment may be organ puncture, nerve damage, or spontaneous miscarriage. I agree to inform my practitioner if I am or may be pregnant. Because acupuncture uses techniques that penetrate the skin, I am aware of the risk of infection, but have also been made aware that this facility uses only single-use, surgically sterilized, disposable acupuncture needles, and that the facility is committed to maintaining a safe and clean environment. I understand that burns and/or scars are possible with moxibustion and that bruises lasting upwards of one week are probable with cupping. I am aware that this list of possible effects is not all-inclusive and I agree to inform my practitioner immediately if I have any adverse reactions to treatment. I am aware that it is not possible for my practitioner to anticipate or explain all of the possible side effects of treatment.

My signature below affirms that I understand the content of this consent to treatment and I intend this consent to treatment to be valid for the entire course of treatment for my present condition and any future conditions for which I might seek treatment.

To be completed by patient (or patient's representative if the patient is a minor or is physically or legally incapacitated).

Patient or Guardian Signature: ___________________________________ Date: ____________________________

Printed Name of Patient: ___________________________ Printed Name of Guardian: _________________________