



## *Hands-On Consent Form*

### **Informed Consent to Acupuncture Treatment**

I consent to acupuncture treatments and other clinical procedures associated with the practice of Oriental medicine provided by members of the Hands-On Health clinical staff. Our clinical staff are New York State licensed acupuncturists. I have discussed the nature and purpose of my treatment with the member of the clinical staff named below. I understand that methods of treatment may include, but are not limited to acupuncture, nutritional and herbal formulas, moxibustion (herbal heat therapy), cupping, electrical stimulation, bodywork therapy, dietary and lifestyle counseling, and infrared heat.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needle sites that may last a few days, dizziness or fainting. Bruising is a common and desired side effect of cupping. Very rare risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although this clinic uses sterile, disposable needles and maintains a clean and safe environment. Our staff acupuncturists are nationally-certified in Clean Needle Technique. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment, other side effects may occur.

I am aware that my practitioner may recommend herbal and nutritional supplements that are derived from plant, animal and/or mineral sources. Natural medicine is considered safe in the practice of wholistic medicine, when recommended by a licensed health professional trained in their appropriate use. Some possible, though unusual, side effects of taking herbal and nutritional medicine include nausea, gas, stomachache, vomiting, diarrhea, rashes, hives and tingling of the tongue. Some formulas may be toxic in large doses, so I will not exceed the dosage recommended by my practitioner.

I understand that some herbs are inappropriate during pregnancy, and that my practitioner is aware of which ones are appropriate during pregnancy. It is my responsibility to notify a clinical staff member who is caring for me if I am or become pregnant, or if I am taking prescription medications.

I understand that some herb formulas need to be prepared, and the liquid consumed, according to the instructions provided by my practitioner. The herbs may have 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 herbal liquids or other natural medicine.

I do not expect the clinician who is caring for me to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on their judgment to make clinical decisions, based upon the facts known to them, which are in my best interests.

I understand the clinical and administrative staff may review my medical records and lab reports. Portions of my records may be used for teaching or research purposes, though my name and identifying information will not be disclosed. Otherwise, my records will be kept confidential and not be released to any party without my written consent.

By voluntarily signing below, I show that I have read, or have had it read to me, this consent to treatment. I 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(s) and for any future condition(s) for which I seek treatment.

I also agree to the following office cancellation policy: Appointments need to be cancelled 24 hours in advance. If an appointment is cancelled less than 24 hours in advance (and the office is unable to fill my appointment time), or the appointment is forgotten (I do not come or call), there will be no charge the first time. After that, I will pay the normal fee.

*To be completed by patient, or patient's representative, if the patient is a minor or is physically or legally handicapped:*

Name of Patient (print) \_\_\_\_\_

Name of Patient Representative (if applicable) \_\_\_\_\_

Signature of Patient or Representative \_\_\_\_\_

Date \_\_\_\_\_

*To be completed by a member of the clinical staff providing information and obtaining consent:*

Name of Clinical Staff (print) \_\_\_\_\_

Signature of Clinical Staff \_\_\_\_\_

Date \_\_\_\_\_

***Hands-On Health Wholistic HealthCare Centers***  
**Natural Family HealthCare Since 1990**

*Put your health back into your own hands... with ours.®*

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## *Hands-On Advisement*

### **For Acupuncture Patients**

New York State Education Law, section 8211b, requires that every patient being treated by a licensed acupuncturist be advised to consult a physician for the condition they are seeking acupuncture treatment for. It reads as follows:

Each acupuncturist licensed pursuant to this article, shall advise each patient as to the importance of consulting with a licensed physician regarding the patient's condition and shall keep on file with the patient's records, a form attesting to the patient's notice of such advice. Such form shall be in duplicate, one copy to be retained by the patient, signed and dated by both the acupuncturist and the patient and shall be prescribed in the following manner:

We, the undersigned, do affirm that \_\_\_\_\_ (the patient) has been advised by, \_\_\_\_\_ (a licensed acupuncturist), to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Acupuncturist's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Thank you!*

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