

Informed Consent – Acupuncture Facial

Blue Peacock Acupuncture

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I (the signer of this document) freely choose to undergo facial rejuvenation acupuncture treatments, knowing that there are no guaranteed results, and I am free to stop acupuncture treatment at any time.

I understand that while acupuncture is generally a safe method of treatment, certain adverse effects may result from treatment. These may be, but are not limited to fainting, some local bruising, puffiness, redness, blood, and temporary pain or discomfort at the site of the needles during or after the treatment.

I understand the methods of treatment in the scope of Chinese medicine may include but are not limited to acupuncture, cupping, moxibustion (applying heat to acupuncture points), electro-acupuncture (electrical stimulation on the needles), Tui-Na (Chinese massage), and herbal medicine.

I understand the acupuncturist is not providing Western medical care, and I should look to my Western primary care physician (MD) for those services and routine checkups.

I understand I must inform my acupuncturist if I am pregnant, HIV positive or have AIDS, cancer, hepatitis, severe migraines, high blood pressure, if I have a cold or flu, are having an acute herpes outbreak, or an acute allergic reaction, as these are all contraindications for facial acupuncture.

I understand all fees for services are due at the time of service, and I will be charged the full fee for appointments that are cancelled with less than 24 hours notice.

I have read, or have had read to me, and completely understand the risks and benefits of acupuncture treatment, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present treatment and for any future condition(s) for which I seek treatment.

Patient name (please print)

Date

Patient signature

Date

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