PHYSIO HEALTH

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INFORMED CONSENT FOR ACUPUNCTURE

I consent to the administering of medical acupuncture and other ancillary techniques as deemed appropriate by my treating practitioner.

Acupuncture has been explained to me as a therapeutic treatment performed by the insertion of single use, sterile, disposable needles. The needles are inserted through the skin into the underlying muscles and tissues at specific points on the body to reduce pain, decrease muscle tone and re-establish normal function.

Ancillary techniques of acupuncture as mentioned above may include one or more of the following:

- ***Electro-acupuncture*** - acupuncture needles are electrically stimulated at various frequencies to increase therapeutic benefit
- ***Dry needling*** - an acupuncture needle is inserted directly in a myofascial trigger point with or without manipulation of the needle to alleviate pain and spasm

I understand that there is the possibility of temporary complications that may result from an acupuncture treatment, which include, but are not limited to, minor bleeding or bruising, minor pain or soreness, nausea, weakness, fatigue, fainting, or aggravation of existing symptoms for a short time. I understand that if there are any particular risks that apply to my case, my practitioner will discuss these with me.

I further state that the following conditions do not exist in my current state of health and that I will immediately notify my practitioner of any changes regarding the following:

- Pregnancy
- Pacemaker
- Bleeding disorder
- Elevated risk of infections
- Local Infections
- Seizure Disorder(i.e. Epilepsy)
- Organic condition

I wish to rely on the practitioner to exercise proper judgment during the course of the treatment and to make decisions based upon my best interests. With all safety precautions, techniques and training, I expect the risks to be minimal. I understand the results are not guaranteed.

I have read the above consent form. I have had an opportunity to ask questions about its content, and by signing below, I agree to the above mentioned acupuncture procedures. I intent this consent form to apply to entire course of my treatment for present and future conditions for which I seek treatment. I understand that I can refuse treatment at any time.

- ☐ **I understand** that the service fees may not be covered or exceed my plan or claim benefits and I am financially responsible for the entire cost of any unpaid claims.
- ☐ **Cancellation Policy:** Each appointment is booked and that time is reserved for you. We require 24 hour notice to cancel your appointment. Any missed or cancelled appointments without the required 24 hour notice will be charged a **$25 cancellation fee**. This fee is not covered by your extended health provider and you will be responsible for covering the cost. **Initial required** _____

_____	_____	_____
Patient/Guardian (please print)	Patient/Guardian (signature)	Date
_____	_____	_____
Therapist/Practitioner (please print)	Therapist/Practitioner (signature)	Date