SAMPLE ACUPUNCTURE INFORMED CONSENT

I, _____, hereby consent
(Insert Name of Patient)

_____, a licensed Acupuncturist,
(insert Name of Practitioner)

to perform treatment according to the professional standards of the Acupuncture Practice Act of this state. This consent is extended to include his/her designated assistants and associates.

This authority shall extend to remedying any unforeseen conditions or reactions to treatment procedures.

_____ has discussed with me the treatment
(insert Name of Practitioner)

of my condition including the following information:

1. The nature and purpose of the proposed procedure(s):
   _____
   _____
2. The benefits and risks of the proposed procedure(s):
   _____
   _____
3. The benefits and risks of no treatment/procedure:
   _____
   _____
4. I acknowledge that no guarantees, warranties, or representations regarding the success of the treatment/procedure have been given to me.
5. I acknowledge that I have been given the opportunity to discuss my condition and proposed treatment/procedure and that all my questions have been answered to my satisfaction, so that I have sufficient information to make an informed decision to undergo the proposed treatment/procedure.
6. I consent to additional procedures from those described herein that the named acupuncturist and his/her associates and assistants deem necessary and appropriate during the course of the proposed treatment/procedure.
7. I understand that there are possible side effects to my treatment that may include the following:
   a. Minor pain or soreness in the treatment areas
   b. Transient bruising
   c. Infection
   d. Needle sickness (dizziness, nausea, fainting)
   e. Broken needles
   f. Sensations of heat, cold, tingling or numbness
   g. Skin irritation or slight bleeding at needle site
   h. Generalized fatigue
   i. Gastrointestinal disturbance from herbal remedies

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I hereby acknowledge that the information described herein has been explained by the named Acupuncturist, that I have read and fully understand this consent document, and that this consent is given voluntarily and without reservation.

Date	Signature of Patient
Date	Witness to Signature of Patient

If patient is a minor, unconscious, or lacks capacity to give consent, the following should be completed:

Date	Signature of Patient's Legal Guardian or Closest Available Relative
Date	Witness to Signature of Patient's Guardian or Closest Available Relative

PROVIDER ATTESTATION

I _____, attest that this patient or the representative named above has been informed about the common foreseeable risks and benefits of undergoing the test/procedure/operation/treatment, as well as its reasonable alternative(s), if any. Further questions with respect to this procedure have been answered to his/her apparent satisfaction. Should the patient or patient representative seek further information pertaining to this matter, I will supply such information upon written or oral request.

Date	Acupuncturist Signature

This sample form is for illustrative purposes only. As each practice presents unique situations, we recommend that you consult with your attorney prior to use of this or similar forms. This document is not intended to represent a comprehensive study of risk management practices or potential liabilities and is not to be considered legal advice. CNA HealthPro strongly recommends consultation with an attorney regarding specific issues related to your organization's legal obligations and applicable state laws. It is further acknowledged that CNA accepts no liability from any use or reliance on this information or any of its contents.