Acupuncture Consent Form

By signing below, I _____ do voluntarily consent to be treated with acupuncture by a licensed acupuncturist at the Graf Center for Integrative Medicine at Englewood Hospital in Englewood, New Jersey and agree to accept the following terms.

Acupuncture: I understand that acupuncture is performed by the insertion of single use of sterile needles through the skin, to normalize the body's physiological functions. Acupuncture is typically a safe method of treatment however certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, dizziness, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop the acupuncture treatment at any time. I therefore give my permission and consent to treatment.

Pregnancy: I will notify the acupuncturist should I become pregnant or if I am in the process of trying to become pregnant so my practitioner can avoid points that could induce miscarriage. If you are pregnant or trying to become pregnant, we will require clearance from yourobstetrician before treatment.

Electro- Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: mild electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment. I do not expect the attending Licensed Acupuncturist, to be able to anticipate and explain all possible risks and complications of treatment. I have carefully read and understand all the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation of anything regarding my treatment.

I have carefully read and understand all the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation of anything regarding my treatment. I understand that the Medical Center is authorized to release my medical records in accordance with Federal and New Jersey State Law, including the Health Insurance Portability and Accountability Act (HIPAA).

I understand that Acupuncture treatment is not an exact science, and I acknowledge that no guarantees or assurances have been made as to the results that may be obtained from acupuncture treatment.

By signing below, I show that I have read, or have had read to me, the above consent to acupuncture treatment, have been informed about the risks and benefits of such treatment 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 and for any future conditions for which I seek treatment.

I have also been advised as to the importance of consulting with a licensed physician regarding my condition prior to or any time during my acupuncture treatment.

SIGNED: _____ Date: _____/_____/_____

I acknowledge that I have been provided with a copy of Englewood Hospital and Medical Center's Notice of Privacy Practices.

SIGNED: _____ Date: _____/_____/_____

Advisory to Consult a Licensed Physician

In accordance with laws set by the New Jersey State Board of Medical Examiners regarding acupuncture, you are advised of the importance to consult with a licensed physician regarding your condition prior to or at any time during your acupuncture. By signing below, you acknowledge this advice has been explained to you by the attending acupuncturist.

I _____have been hereby advised by the acupuncturist below as to the importance of consulting with a licensed physician regarding my condition prior to or any time during my acupuncture treatment.

Patient Signature: _____ Date: _____/_____/_____

Acupuncturist Signature: _____ Date: _____/_____/_____