Treatment Consent Form

Madison Acupuncture & Complementary Medicine, LLC

By signing below, I do hereby voluntarily consent to be treated by a licensed acupuncturist at Madison Acupuncture & Complementary Medicine, LLC. I understand that Acupuncturists practicing in the state of Wisconsin are not considered to be primary care providers. The practitioner at Madison Acupuncture & Complementary Medicine, advise you to consult a primary care provider in addition to Acupuncture & Oriental medicine treatment.

Acupuncture: I understand that acupuncture is performed by the insertion of single use, sterile needles through the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and 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, infection, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. In very rare situations, organ puncture can occur, including pneumothorax. 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.

Pregnancy: I will notify the acupuncturist should I become pregnant or if I am in the process of trying to become pregnant so that my practitioner can avoid specific points and herbs that are contraindicated in pregnancy. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

Chinese Herbs, Nutritional Supplements and Lifestyle/Diet Counseling: I understand that Chinese medicinal herbs and/or nutritional supplements may be recommended to me (via office visits and/or telehealth visits) to support health, modify or prevent pain perception and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, nausea & vomiting, and the possible aggravation of symptoms existing prior to treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and call the clinic or your primary care provider.

Acupressure / Tui-Na Massage: I understand that I may also be given acupressure / tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse the treatment or stop the treatment at any time for any reason.

Moxibustion: I understand that moxibustion means the therapeutic application of direct or indirect heat to the skin at certain points on or near the surface of the body. I have been made aware that if I receive direct moxibustion as part of therapy, there is a risk of burning, blisters or scarring from its use. I understand that I may refuse this therapy.

Cupping / Gua Sha: I understand that I may also be given cupping (the application of glass cups with vacuum to the skin) and Gua Sha (rubbing of the skin with a smooth object such as a porcelain spoon) as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that these treatments are intended to cause minor bruising and though unsightly are not normally painful. However certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse the treatment or stop the treatment at any time for any reason.

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: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

Special Situations: Please inform us if you have any allergies, severe bleeding disorders, diabetes, lymphedema, infectious disease-such as HIV / AIDS, hepatitis, tuberculosis, or if you are wearing a pacemaker or other electronic medical device.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks is best at the time based upon the facts then known. I understand that results are not guaranteed. I understand that the acupuncturist is not providing Western (allopathic) medical care, and that I should look to my primary care practitioner (i.e., M.D.) for those services and for routine check-ups.

I request and consent to the performance of acupuncture and Oriental Medicine procedures and nutritional recommendations/ supplementation. I understand that I am free to withdraw my consent and that I may stop treatment or any procedure at any time. I understand that my signature in this form indicates that I have read and understand the risks and benefits of acupuncture and other treatments. I have had an opportunity to ask questions and understand that if at any time I have any questions about this information, I should ask my acupuncturist. I hereby release Madison Acupuncture & Complementary Medicine from any and all liability that may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care.

Signature: _____ Date: _____/_____/_____

Printed Name: _____