White Crane
Community Acupuncture

Informed Consent for Acupuncture Treatment

I hereby request and consent to the performance of acupuncture treatments by James A Sears. Treatments may include needling, cupping, and heat therapy.

I have been informed that acupuncture is generally a very safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling at the needle sites that may last a few days, dizziness, or fainting. Bruising is a common side effect of acupuncture and cupping- occasionally, bruises may be large. Burns and/or scarring are a potential risk of moxabustion and cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I will notify a clinical staff member if I am or become pregnant.

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 at the time, based upon the facts then known, is in my best interest. I understand that results may take several weeks and are not guaranteed. It has been explained that I may initially have more adverse symptoms, though this is rarely an issue.

I understand that acupuncture is not a substitute for medical diagnosis and treatment.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture 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 condition(s) for which I seek treatment.

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Patient Signature Date (relation to patient if not self)

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Office Signature Date