Acupuncture Patient Information and Consent Form

Please read this information carefully, and ask your practitioner if there is anything that you do not understand.

What is acupuncture?

Acupuncture is a form of therapy in which fine needles are inserted into specific points on the body.

Is acupuncture safe?

Acupuncture is generally very safe. Serious side effects are very rare – less than one per 10,000 treatments.

Does acupuncture have side effects?

You need to be aware that:

drowsiness occurs after treatment in a small number of patients, and, if affected, you are advised not to drive;
minor bleeding or bruising occurs after acupuncture in about 3% of treatments;
pain during treatment occurs in about 1% of treatments;
symptoms can get worse after treatment (less than 3% of patients). You should tell your acupuncturist about this, but it is usually a good sign;
fainting can occur in certain patients, particularly at the first treatment.

In addition, if there are particular risks that apply in your case, your practitioner will discuss these with you.

Is there anything your practitioner needs to know?

Apart from the usual medical details, it is important that you let your practitioner know:

if you have ever experienced a fit, faint or funny turn;
if you have a pacemaker or any other electrical
implants; if you have a bleeding disorder;
if you are taking anti-coagulants or any other medication;
if you have damaged heart valves or have any other particular risk of infection.

Single-use, sterile, disposable needles are used in the clinic.

*** Each treatment is $30.00 to$50.00 and we do not submit to insurance ***

Statement of Consent

I confirm that I have read and understood the above information, and I consent to having acupuncture treatment. I understand that I can refuse treatment at any time.

Signature _____

Print Name _____ Date _____

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Patient Wavier of Insurance Coverage

I have chosen under my own will and testament to not utilize my health coverage. It is my legal right as the policy holder to make this choice. This agreement will supersede any provider contract language that would require **Dr. McClure** to submit my care. I understand in making this choice I will be financially responsible for all care received in this office. I also understand at no time will I or **St. Henry Chiropractic** office submit any care to my insurance in effort s to meet deductibles and/or seek reimbursement.

Should I choose to begin utilizing my insurance benefit I must notify this office in writing prior to receiving care.

_____ _____

Patient's Printed Name Date

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Patient's Signature