

## INFORMED CONSENT

I do hereby voluntarily consent to be treated with acupuncture and/or herbal medicine administered by the licensed acupuncturist, Colleen Cole, LAc. I understand that methods of treatment may include, but are not limited to, Acupuncture, Herbs, Cupping, Moxibustion, Electrical Stimulation and Tui-Na (Chinese Massage). The course of the treatment will be determined between the health practitioner and myself (the patient).

I understand that acupuncture is performed by the insertion of needles through the skin, or by the application of heat to the skin, or by both, at certain points on or near the surface of the body and that certain side effects may result. The side effects from acupuncture, as well as the other modalities, may include, but are not limited to, some local bruising, minor bleeding, temporary pain or discomfort, the possible temporary aggravation of symptoms existing prior to acupuncture treatments, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. 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 understand that no guarantees concerning use and effects are given to me, and that I am free to stop acupuncture treatments at any time. I understand that the acupuncturist may recommend substances from the Oriental Materia Medica to treat bodily dysfunctions or diseases to modify or prevent the perception of pain. I understand that I am not required to take the herbal medicine, but must follow the directions for administration and dosage if I decide to take them. I understand that certain adverse side effects may result from taking the herbal medicine. These could include, but are not limited to, changes in bowel movement, temporary abdominal pain or discomfort, and the possible temporary aggravation of symptoms existing prior to herbal treatment. I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment, which the clinical staff thinks at the time, based upon the facts that are then known, is in my best interest. I understand that results are not guaranteed.

Should I experience any problems which I associate with the herbal medicine, I should suspend taking them and contact Colleen Cole, LAc. I also understand that appointment times are reserved. I agree to give 24 hours notice to Colleen Cole, LAc and to take myself off the online schedule in the event that I must cancel or re-schedule an appointment. I understand that I will be charged the full fee for every late cancellation or missed appointment.

I understand that in case of any unavoidable lateness made by me or the practitioner, the schedule may be adjusted to provide for my treatment in its entirety.

Unless other arrangements have been made, I understand that payment is due at the end of each visit, in the form of cash or check.

Signature of Patient or Guardian of Patient: \_\_\_\_\_

Print Name of Patient or Guardian of Patient: \_\_\_\_\_

Date \_\_\_\_\_