Dr. Laura Pipher, ND

**Informed Consent for Acupuncture Care Form**

*Please Read Carefully*

Acupuncture involves the insertion of small sterilized needles into specific locations on the skin surface. Other procedures related to acupuncture include moxibustion, cupping and electroacupuncture.

**Benefits**: Acupuncture and procedures related to acupuncture have been demonstrated to be a safe and effective form of treatment for a range of conditions

**Risks** The risks associated with acupuncture include minor bleeding and bruising, temporary pain and soreness, nausea, fainting, burns, infection, shock, convulsions, pneumothorax, perforation of internal organs, and stuck or bent needles.

**Please inform your naturopathic doctor if you:**

* Have or develop any major health issues
* Are pregnant or actively trying to be
* Have been fitted for a pacemaker or other electrical implants
* Have a bleeding disorder or take anticoagulants
* Have damaged heart valves or have a high risk of infection
* Suffer from metal allergies
* Are Immune compromised
* Have had prosthetic implants

Only sterile single use disposable needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

**Pregnancy** The use of certain acupuncture points and treatment techniques may be contraindicated during pregnancy. Advise your naturopathic doctor if you are pregnant or actively trying to be.

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, as necessary, including moxibustion, cupping, and/or electroacupuncture by the abovenamed doctor or another duly authorized doctor in the clinic. I have read this consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-mentioned acupuncture procedures.

**Female Patients:** I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible. I understand that it is critical to disclose the possibility of pregnancy to my practitioner, as this will impact treatment protocols.

Date Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Patient’s Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient (or parent/guardian) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_