Nancy L Smith RN M.Ac., L.Ac., LLC

Informed Consent

I voluntarily request and consent to be treated with acupuncture and other techniques based on traditional Asian medicine, such as moxibustion or other warming treatment. I understand I may be given recommendations on diet, lifestyle and nutritional or herbal supplements and it my decision whether or not to follow theses recommendations. The procedures involved in this treatment have been explained to me. I understand I may be treated with the insertion of needles or other non-insertion techniques such as touch/palpation or the application of heat to the skin. All needles that penetrate the skin are believed to be sterile, prepackaged and are disposed of as medical waste. Each needle selected is only used one time.

I have not been guaranteed any success concerning the uses and effects of these treatments. I understand that I am free to discontinue treatment at any time.

I understand that these treatments may result in certain side effects including local bruising, bleeding, fainting, temporary pain or discomfort, and temporary aggravation of symptoms existing prior to treatment. Unusual and rare risks of acupuncture include nerve damage, organ puncture, and infection. I have read the information in this page and understand the possible risk involved.

I understand that I should consult a licensed physician for appropriate medical evaluation and treatment of the conditions for which I am seeking acupuncture treatment. Treatment from this practitioner does not substitute for appropriate medical treatment by a licensed physician. I have been advised that if there is a worsening of my ailment or condition, or if it does not improve within the time estimated by the acupuncturist at the beginning of treatment, or if a new ailment or condition arises, I should again consult a licensed physician. If I am presently under the medical care of a physician, I have been advised to continue all medications and treatments as prescribed until such time as my physician deems it appropriate to reduce or discontinue the medications or treatments. I certify that I have informed Nancy Smith of all known physical, mental and medical conditions and medications, including possible pregnancy , and that I will notify her of any changes in my health.

I understand that my questions about the safety of any procedure or treatment or the precautions taken by the practitioner are most welcome and will be answered as fully as possible. I understand I have the right to refuse any treatment or procedure. I have read this form carefully and I have felt free to ask any questions. My questions have been satisfactorily answered.

I agree to pay the charges for services rendered. I understand I will be charged for any appointment not cancelled 24 hours in advance unless there is an emergency.

Signature of Patient or Person Authorized to Consent

Relationship or Authority of Representation

Date:_____