Awaken Now Acupuncture & Wellness Inc.

Dr Marina Dabcevic LAc, DAOM

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Informed Consent for Acupuncture Treatment and Care

I ____hereby request and consent to acupuncture treatments and other Oriental medicine procedures, including various modes of physiotherapy on me (or on the patient named below, for whom I am legally responsible) by the below named licensed acupuncturist.

I understand that methods of treatment might include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tuina (Chinese or other massage), Chinese or Western herbal medicine, and nutritional counseling.

I have had the opportunity to discuss with the acupuncturist named below and/or with other office or clinical personnel the nature and purpose of acupuncture treatments and other procedures.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the acupuncture sites that lasts a few days. There have been rare instances reported of fainting, infections, and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping which is an expected result of this procedure.

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal upset or allergic reactions to the herbs I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure that the acupuncturist feels at the time, based upon the facts then known, and is in my best interests.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I am giving my consent to the treatment and care. 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.

Dr Marina Dabcevic Lac, DAOM

Patient's Name:____

Patient's Signature:____

Date Signed: _____/_____/___________ Are you pregnant? o Yes o No

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