Chiropractic & Acupuncture Office

Geraldine Greenberg. D.C., L.Ac

INFORMED CONSENT TO ACUPUNCTURE TREATMENT AND CARE

Print Patient's Name _____

I hereby request and consent to the performance of procedures which are within the scope of practice of acupuncture including, but not limited, to acupuncture treatments on me (or on the patient named above, for whom I am legally responsible) by the acupuncturist named above and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture. I understand that results are not guaranteed.

I understand and I am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, slight bruising, tingling near the needling sites that last a few days, nausea, and infection. There have been instances reported of fainting, infections and scarring. There have been instances reported of spontaneous miscarriage and pneumothorax. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastro-intestinal upset or allergic reactions to the herb, 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 judgement during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interest.

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 agree to the above-named procedures. I intend this consent form to cover the course of treatment for my present condition.

_____ _____

Signature of patient or patient's representative

Print Name of Patient's Representative

_____

Relationship or Authority of Representative

13527-A Ventura Boulevard, Sherman Oaks, CA 91423 • (818) 986-9565