ACUPUNCTURE INFORMED CONSENT TO TREAT

I hearby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Karen Hershman, LAc 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 Karen Hershman, LAc, including those working at the Escondido Healing Center or any other office, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Chinese herbal medicine, and nutritional counseling. I will immediately notify Karen of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping and guasha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although Karen uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect and risks may occur. 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, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify Karen if I am or become pregnant.

I do not expect Karen Hershman, LAc to be able to anticipate or explain all possible risks and complications of treatment, and I wish to rely on her to exercise judgment during the course of treatment which she thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

_____ _____

Patient Signature Date

_____

Patient's Name

I hearby attest that this patient or the representative named above has been informed about the common foreseeable risks and benefits of undergoing the test/procedure/operation/treatment, as well as its reasonable alternative(s), if any. Further questions with respect to this procedure have been answered to his/her apparent satisfaction. Should the patient or patient representative seek further information pertaining to this matter, I will supply such information upon written or oral request.

_____ _____

Karen Hershman, LAc Date