# INFORMED CONSENT FOR ACUPUNCTURE THERAPY

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**Patient's Name:_____ Date:_____**

I, the undersigned (patient/ on behalf of the patient), do request and give my consent to the administration of acupuncture and related therapies as required by Section 45: 2C-5(2) of Professions and Occupations Code of the State of New Jersey. I hereby authorize **Fen Xie, L.Ac**., a Licensed Acupuncturist, 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 above, including those working at the clinic or office listed above, whether signatories to this form or not, to treat me in accordance within the scope of practice for acupuncture in the State of New Jersey. The nature, consequences and benefits of these procedures have been explained to me completely and in detail by the acupuncturist and are reiterated below.

A. I understand the methods of treatments may include, but are not limited to, acupuncture, moxibustion, cupping, thermal methods, electro-stimulation, Tui Na (Chinese massage), Chinese herbs and nutritional counseling.

B. I have been informed that acupuncture is a generally safe method of treatment, but potential risks include discomfort at the site of needle insertion, irritation, pain, bruises, redness, blisters, weakness, fainting, nausea, and possible temporary aggravation of symptoms. These risks may be minimized by proper nutrition and rest prior to treatment, and close communication with the acupuncturist with regards to any uncertainty on the part of the patient.

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

D. Potential benefits are enhanced by avoiding bathing or showering for several hours after treatment, resting appropriately and following such general recommendations as the therapist may make. Acupuncture may allow for painless and drugless relief of presenting symptoms and improved balance of bodily energies which may lead to prevention or elimination of the presenting problem as well as other health enhancing effects.

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 condition(s) for which I seek treatment.

**Patient's/ Guardian's Signature_____ Date _____**