Acupuncture Informed Consent

Acupuncture is performed by the insertion of PRE-STERLIZED, DISPOSABLE, hair-thin acupuncture needles through the skin, and may involve the use of mechanical and/or electrical stimulation to these needles at certain points on the body. All points selected for insertion of acupuncture needles are cleaned with 95% alcohol prior to insertion in order to minimize the risks of infection. I understand that I should remain still while the needles are inserted and retained. Although rare, certain side effects may result from acupuncture. I understand that risks and potential side effects for acupuncture exist, including, but not limited to:

● Aggravation of pre-existing symptoms ● Some pain, bruising, or injury at the site of needle insertion ● Needle sickness (dizziness, fainting, nausea, or loss of consciousness following needle insertion) ● Infection and risks from needling in the vicinity of an infection ● Broken needles ● Unusual risks include spontaneous miscarriage, nerve damage, organ puncture, including pneumothorax (lung puncture).

I understand that each treatment procedure has specific risks and benefits. I have been informed of the risks and benefits of the treatment procedures, including the use of **acupuncture needles** to stimulate points and meridians (including the specific risks of needling certain points), use of **mechanical and/or electrical stimulation** of acupuncture points (particularly where stimulation is applied across the midline of the trunk of patients with a history of heart trouble), use of **moxibustion**, use of **gua sha** and/or **cupping**, and use of **acupressure**.

→ _____ **(initial)** To the best of my knowledge, I have provided J. Ragani Buegel, L.Ac., accurate and complete information about present complaints, past illnesses, hospitalizations, medications, surgical interventions, health risks, and other matters relating to my health conditions, and this information is current to date. I understand that ANY unexpected or expected changes in my health condition (including pregnancy, suspected pregnancy, illness, injury, etc.) need to be communicated to all of my healthcare practitioners, including J. Ragani Buegel, L.Ac., in as timely a manner as possible. Treatment records and conversations about treatment will be kept confidential. I understand, however, that all of my healthcare practitioners, including J. Ragani Buegel, L.Ac., are limited in their ability to maintain confidentiality in situations that are life-threatening—i.e. attempts of suicide, attempts to harm others, emergency health situations, etc.

→ _____ **(initial)** Treatments will be performed solely by J. Ragani Buegel, L.Ac., a licensed and board certified acupuncturist. I understand that her training is in acupuncture and Oriental Medicine modalities of treatment, and that she is not, and does not claim to be, a medical doctor. I understand that the evaluation given to me under her care is an energetic assessment that is based upon Oriental medicine (eastern) principles and it not intended to replace allopathic (western) forms of diagnosis or treatment. I understand that results are not guaranteed regarding the utilization of acupuncture and/or Oriental Medicine treatments. I understand that I may choose to terminate treatments at any time. I am choosing to participate in acupuncture and/or Oriental Medicine treatments at this time as an exercise in my right to freedom of choice in the healing arts.

→ _____ **(initial)** I confirm that I have been advised to consult a physician regarding the conditions for which I seek acupuncture treatment.

→ _____ **(initial)** I understand that payment is due at or before the time of treatment and that I am at all times personally and directly responsible for my bill.

→ _____ **(initial)** I understand that a $150 fee will be charged (Missed Appointment Fee) for all missed appointments or late cancellations (less than 24 hours), except for emergencies such as illness, weather conditions, etc.

→ _____ **(initial) RECORDS RELEASE AUTHORIZATION**: I authorize the release of any medical information to my insurance companies, where records may be necessary to process insurance claims, and I permit a copy of this authorization to be used in place of the original. I direct my previous healthcare providers to release medical records to this clinic, where they may be useful for the course of treatment.

Patient's Signature: _____ **Date:** _____

Practitioner's Signature: _____ Date: _____

CONSENT TO TREAT A MINOR CHILD

I authorize the administration of acupuncture and Oriental Medicine treatment as deemed necessary to my

_____ (relationship). Patient's Name: _____

Adult's Signature: _____ Date: _____