

Informed Consent Form

I, the undersigned, hereby authorize the licensed acupuncturist working at Community Acupuncture Studio to perform the following procedures. As outlined in the legal scope of practice of licensed acupuncturists in Washington state (RCW 18.06, WAC 246.802), I understand that these methods of treatment may include but are not limited to the following:

- **Acupuncture:** The insertion of sterile, disposable needles through the skin at specific points on the body.
- **Electroacupuncture:** Using very small amounts of electricity to stimulate specific acupuncture points.
- **Acupressure:** Traditional Chinese medical massage and manual therapy.
- **Infrared Heat:** Applying heat generated by an infrared lamp over a specific area of the body.
- **Dermal-friction:** Friction is applied topically to the skin using a smooth object to relieve symptoms.
- **Cupping:** Glass cups are placed on the skin with a vacuum created by heat or suction device.
- **Dietary Advice:** Suggestions for nutrition and herbal food products.
- **Liniments, Oils, Plasters:** Herbal formulas applied topically to the skin.
- **Moxa:** A soft woolly mass prepared from ground young leaves, typically in the form of sticks or cones which are ignited and placed on or close to the skin or used to heat acupuncture needles.

I recognize the potential benefits and risks of these procedures described below, which include but are not limited to:

- **Potential Benefits:** Drugless relief of presenting symptoms and improved balance of body energies that may lead to the prevention, improvement or elimination of the presenting problem.
- **Potential Risks:** Discomfort, pain, bruising, blistering, bleeding, infection, numbness or tingling at or near the site of the procedure, temporary discoloration of the skin, broken needle, needle sickness, possible aggravation of symptoms existing prior to the acupuncture treatment, and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including pneumothorax.

Patients with **bleeding disorders** or **pacemakers** as well as **pregnant** patients should inform the practitioner prior to receiving treatment

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Community Acupuncture Studio or any of the employees or associates regarding cure or improvement of my condition. By signing below I acknowledge that I have read the above consent to treatment, have been informed about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I hereby release Community Acupuncture Studio and all employees and associates from any and all liability, which may occur in connection with the treatments and above-mentioned procedures. I understand that I am free to withdraw this consent and to discontinue participation in these procedures or treatments at any time.

Signature of patient

Date