Amira Pinsker, M.Ac R.Ac CPT

INFORMATION AND CONSENT TO SERVICES

Services To Be Provided

I understand that acupuncture serves individuals with a wide range of complaints including both acute and chronic healthcare issues. I understand that I may be treated with the insertion of needles and/or with the application of heat to the skin. I may also be treated with vacuum cups or manual therapy including moxibustion, and gua sha scraping technique as deemed appropriate by the practitioner.

Risks/ Possible Side Effects/ Healing Response

I understand that acupuncture may result in certain side effects. Although rare, they may include local bruising, slight bleeding, slight skin reaction or itching, fainting, and temporary pain and discomfort. Another occurrence may include a temporary aggravation of symptoms existing prior to treatment. This is a part of the healing response and should subside within 24 to 72 hours of treatment.

No Guarantees

I know that each person is unique and has ultimate responsibility for his or her own healthcare. I acknowledge that I have not received any guarantees or promises as to the results or success that will be obtained from the services provided.

Infectious Disease Prevention

I understand that infectious diseases are carried through the air, through physical contact, and through body fluids. I understand that my practitioner is certified in Clean Needle Technique and follows universally prescribed precautions including the use of sterile disposable needles.

Patient Responsibility

I understand that it is my responsibility as a patient to inform my practitioner about all aspects of my health and, as service progresses, to inform my practitioner of changes that occur. If I experience any pain, discomfort, or possible adverse side effects it is my responsibility to immediately notify my practitioner. I also understand that acupuncture is not a substitute for medical care. Should an emergency occur, my regular physician should be notified.

Cancellation Policy

I understand that I need to cancel and appointment no later than 24 hours before my treatment time. If I do not do so, I agree to pay the entire fee of the session cancelled. I also understand that should I not show up for a scheduled appointment, I will pay for the missed session at the next treatment.

Consent to Services

I have read completely and understand this form. I hereby voluntarily consent to acupuncture treatment.

_____ _____

Patient Signature **Date**

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Printed Name of Patient