SARANA COMMUNITY ACUPUNCTURE

970 San Pablo Avenue
Albany, CA 94706

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510.526.5056

INFORMED CONSENT TO RECEIVE ACUPUNCTURE

I, the undersigned, hereby authorize Sarana Community Acupuncture's acupuncturists, licensed in the State of California, to perform Chinese Medicine treatments that may include acupuncture, electrical stimulation, moxibustion, cupping, Gua Sha, bleeding techniques, herbal therapy, or dietary and lifestyle recommendations. This authority shall extend to remedying any unforeseen conditions or reactions to treatment(s).

I understand that Sarana Community Acupuncture uses only sterile disposable needles and maintains a clean and safe environment.

I understand that these treatments are all safe, natural methods of healing and I recognize the potential risks and benefits of these procedures as described below:

POTENTIAL BENEFITS: I understand that I may experience relief of symptoms, improved sense of well-being, reduced stress and an overall balance of bodily energies which may lead to prevention or elimination of my main complaint(s).

POTENTIAL RISKS: I understand that there are uncommon but possible side effects of acupuncture treatment that may include the following: minor pain or soreness in the treatment areas that may last up to a few days, temporary bruising / swelling, sensations of heat / cold / tingling or numbness, skin irritation or slight bleeding at needle site, generalized fatigue, temporary aggravation of symptoms.

I understand that there are very rare side effects to acupuncture treatment that may include the following: infection at needle site, needle sickness (dizziness, nausea, fainting), broken needles, pneumothorax.

I understand that some uncommon but possible side effects of Chinese herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must follow the dosage and directions of the acupuncturist, and I will stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.

DISCLOSURE: I agree to contact my practitioner immediately if I experience any problem which I associate with the treatments listed above and will seek immediate help from a physician / hospital if I experience a medical emergency. During the course of treatment, I agree to inform my acupuncturist of all health issues and medication changes.

PREGNANCY: I will notify my acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce premature labor or miscarriage.

PRIVACY: I understand that acupuncture at *Sarana Community Acupuncture* is conducted in a group setting. I understand that my conversations in the group room may be overheard by others receiving treatment nearby. I understand that if I need to have a private conversation with the acupuncturist, it is best to do so by telephone or by e-mail.

I understand that *Sarana Community Acupuncture* may record medical and other information concerning my treatment. I understand the clinical and administrative staff of *Sarana Community Acupuncture* may review my patient records, but all my records will be kept confidential and will not be released without my written consent, except when bound by law to do so. I understand that *Sarana Community Acupuncture* abides by state and federal regulations regarding patient privacy and I know that I can ask for more information regarding these regulations.

I understand that I have the right to request to receive a copy of my medical records as maintained by *Sarana Community Acupuncture.* I permit a copy of this authorization to be used in place of the original.

I do not expect the clinical staff of Sarana Community Acupuncture 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. I voluntarily consent to the above procedures and policies, realizing that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments regarding the cure or improvement of my condition(s). I hereby release the acupuncturists of Sarana Community Acupuncture from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the treatments with appropriate skill as required by their licenses. I understand that I am free to withdraw my consent and to discontinue participating in these procedures at any time.

CONSENT TO TREAT A MINOR CHILD: I authorize the clinical staff of *Sarana Community Acupuncture* to administer Acupuncture and Oriental Medicine as deemed necessary to:

Child's printed name:_____, who is my _____(relationship)

SIGNATURE OF PATIENT (or Adult Authorized to Consent) _____

PRINT NAME_____ **DATE**_____ **(OVER)**