7369 East Kemper Road Suite A

Cincinnati, OH 45249

ACUPUNCTURE INFORMED CONCENT TO TREATMENT

I hereby request and consent to the performance of acupuncture and other treatments within the scope of practice of an acupuncturist to be performed by **Inesa Zelepuhin L.Ac**., representing **Cincinnati Acupuncture Clinic,** on me (or, if the patient is a minor, on the patient named below, for whom I am legally responsible).

I understand that methods of treatment may include, but not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Gua –Sha, heat and/or cold therapy.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scaring are potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve, damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that I have opportunity to discuss the nature and purpose of acupuncture and oriental medical procedures. Although I am aware that acupuncture and other procedures used in oriental medicine helped millions of people, I understand there is no guarantee of cure or improvement in my condition is given or implied.

I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioner to exercise such judgment, during the course of my treatment, as the practitioner feels at the time, based on facts then known, to be in my best interest.

I understand the practitioner and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that if I need to reschedule an appointment for any reason, I will give at least 24 hour notice or be responsible for half the session fee. If I don't call or show up, I will be responsible for the full session fee.

By voluntarily signing below, I show that I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for future condition(s) for which I seek treatment at Cincinnati Acupuncture Clinic.

_____	X _____	_____
Patient's Name (please print)	Patient's Signature	Date
_____	_____	
Print Name of Patient's Representative (if applicable)	Relationship to Patient	
_____	_____	
Signature of Patient's Representative (if applicable)	Date	