

## Informed Consent for Acupuncture Treatment and Care

I hereby request and consent to the performance of acupuncture treatments and other complementary medicine procedures including various modes of physio-therapy on (or on the patient named below, for whom I am legally responsible) by **Alison Leiner, L.Ac.**

I understand that methods or treatment may include, but are not limited to: acupuncture, moxibustion, cupping, moving cupping, electrical stimulation, Tui-Na (Chinese Massage), Chinese or Western herbal medicine, supplement recommendations, and nutritional counseling.

Acupuncture attempts to normalize physiological functions and the movement of Qi (energy), to modify the perception of pain, and to treat certain dis-eases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites. There may be some stagnation visible after cupping.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal upset or allergic reactions to the herbs, I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications. I wish to rely on the acupuncturist to exercise judgment during the course of treatment which serve my best interests. I understand and will rely on my acupuncturist to explain treatment procedure when necessary or when I feel the need to ask for my own understanding and feeling of security.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my consent in accordance with standard HIPPA Laws. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content.

I understand my patient records and patient information will be kept confidential and shared only when necessary to provide care and services, or by my authorization, or when required or permitted by law.

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 any future condition(s) for which I seek treatment. If I have gone 4 months without treatment, I understand I may be required to sign an additional consent form that will be kept with my previous medical records.

Patient's Name \_\_\_\_\_

Patient's/Patient Representative's Signature \_\_\_\_\_

Today's Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

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