Leonard Melamed
Acupuncture Physician

AcupunctChi Clinic

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Consent Form for office treatment

By signing below, I do hereby voluntarily consent to be treated with Acupuncture, Tui-Na Massage, Traditional Chinese Medicine, Homeopathy and Hypnosis by the Licensed Acupuncturist ,Reiki , Shiatsu specialist and Certified Hypnotherapist , of the Massotherapy Rehabilitation Clinic Inc., AKA AcupunctChi Clinic.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time. _____

Cupping: I understand that if I receive cupping as part of therapy, there is a likelihood of bruising and/or discoloration on the body-area on which cupping is preformed. There may also be a slight probability of mild discomfort from this procedure. I understand that I may refuse this therapy. _____

Homeopathy: I understand that substances from the Homeopathic Materia Medica may be recommended to me to heal bodily symptoms or dysfunctions, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to : changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to use of Homeopathy. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call AcupunctChi Clinic immediately.* _____

Acupressure/ Tui-Na Massage: I understand that I may also be given acupressure/Tui-Na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable. _____

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment. _____

I acknowledge that the proposed procedure, the potential risks and benefits, and the possible complications of such procedure have been explained to me as well as the possible risks and benefits of not undergoing this procedure. I further acknowledge that alternative methods of available treatment were discussed with me, and that I was given adequate opportunity to ask questions pertaining to this procedure and the alternative methods. No guarantee or assurance has been given by anyone as to the results that may be obtained from this procedure.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature:_____Date

Signature:_____Date
Signature of parent or guardian if patient is a minor (under 18 years of age)

Name: _____ Date of birth: _____

Address: _____

SIGN BELOW *ONLY* IF YOU REQUESTED AND RECEIVED MORE DETAILED INFORMATION
I requested and received in substantial detail further explanation of the procedure or treatment other alternative procedures or methods of treatment and information about the material risks of the procedure or treatment. I give my permission and consent to treatment.

X_____**X**_____

Patient's Signature and Date Explained by me & signed in my presence / date