The Turning Point: A Community Acupuncture Center
243 W. Patrick Street, Frederick, MD 21701
(240) 405-7878
www.TheTurningPointAcupuncture.com

ACUPUNCTURE INFORMATION AND INFORMED CONSENT

I understand that acupuncture involves the insertion of presterilized, disposable needles through the skin at specific points and that additional therapies (such as herbal therapy, Asian nutrition therapy, acupressure, cupping therapy, electrical stimulation to the skin, and TDP heat lamp) may be suggested to support the treatment process. All therapies will be fully explained before administration. Side effects such as local bruising, needle sickness, broken needles, pain at site of insertion, infection, pneumothorax, spontaneous miscarriage, burns from use of moxabustion, and allergic reaction (with herbs) are rare but possible.

If I agree to take herbal medicine, I understand that I must follow all administration and dosage instructions. I understand that my practitioner is providing dietary guidance based on Asian medicine principles of nutrition and is not a licensed dietician. During the course of treatment, I agree to inform my practitioner of all health and medication changes, especially possible pregnancy. I agree to contact my practitioner immediately if I experience any problem which I associate with the treatments listed above and will go immediately to the hospital if I experience a medical emergency. I understand that acupuncturists practicing in Maryland are not primary care providers and that treatment alternatives may be available from a physician. Physician care is recommended. I consent to receive the therapies listed above, understand the risks and understand that I may refuse any treatment at any time.

I understand that the practice of Acupuncture and Oriental medicine is not an exact science and I acknowledge that no guarantees have been made to me as the result of treatment.

I understand that acupuncture is conducted in a group setting at *The Turning Point.* I understand that my conversations in the group room may be overheard by others sitting nearby. I understand that if I need to have a private conversation with the acupuncturist, it is best to do so by telephone, by e-mail, or by scheduling an appointment to talk privately.

I understand that *The Turning Point* may record medical and other information concerning my treatment. I understand that *The Turning Point* abides by federal regulations regarding patient privacy as defined under 45 CFR 164.528. I know that I can ask for more information regarding this procedure. I permit a copy of this authorization to be used in place of the original. This authorization is not intended to allow the release of records regarding my treatment for services requiring a restricted release under State or Federal Law.

Patient's Signature ______________________________ Date _____________

Patient's Printed Name: ____

Witness Signature ________________________________ Date ____________

CONSENT TO TREAT A MINOR CHILD

I authorize *The Turning Point* to administer Acupuncture and Oriental Medicine as deemed necessary to ____________________ who is my ______________________ (relationship).

Adult's Signature ________________________________ Date _____________

Witness Signature _______________________________ Date ____________