Informed Consent for Treatment

Minneapolis Community Acupuncture 612-708-8917 www. mplsacu.com

I understand that the scope of practice of acupuncture according to Minnesota State Law includes, but is not limited to, acupuncture, which has benefits for specific types of problems. We use ORIENTAL MEDICAL THEORY to assess and diagnose patients and develop a treatment plan. Treatment may include insertion of sterile, single use, disposable acupuncture needles through the skin as well as other adjunct modalities.

RISKS OF THE ABOVE THERAPIES:
Acupuncture needles inserted into the skin can cause pain or discomfort, bruising, infection, broken needles, a feeling of weakness, fainting or nausea. **Risk of fainting, weakness and nausea are increased with an empty stomach and also with the use of alcohol or other recreational drugs**.

I hereby acknowledge that I have been advised of the benefits and risks of acupuncture and adjunct modalities. I understand these risks and benefits and consent to accept treatment using these methods. I agree to release the below named acupuncturist from all legal responsibility for practices done here except in the case of negligence or unsafe practices on the part of said acupuncturist.

I understand that Deborah Owen, L.Ac. has completed a Master's degree in the field of Oriental Medicine including courses in acupuncture and related modalities, herbalism, and Oriental dietary therapy and required Western Medical studies.

I understand that Deborah Owen, L.Ac. is licensed with the Minnesota Board of Medical Practice and is board certified with The National Certification Commission for Acupuncture and Oriental Medicine.

Please check the appropriate phrase:

____I **do have** a pacemaker or bleeding disorder. ____I **do not** have a pacemaker or bleeding disorder.

____I **have** a history of seizures. ____I **do not have** a history of seizures.

____I **have been** examined by a physician or other licensed health care provider within the last year.

____I **have not been** examined by a physician or other licensed health care provider within the last year.

(You are advised to see your physician about the problem for which you have come here to be treated.)

_____ Name (please print)

_____ _____ Licensed Acupuncturist Date

_____ _____ Patient Signature Date