

INFORMED CONSENT TO TREATMENT

I consent to acupuncture treatments and other associated procedures by Corinne Kohrherr, L.Ac.

Methods of Treatment: I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-na massage, Gua Sha and lifestyle counseling. I understand that needles will be inserted in my body and heat, cups, pressure or electrical stimulation may be applied to those needles or my body.

Acupuncture – insertion of fine, sterile, single-use needles into specific points of meridian pathways by a licensed practitioner

Moxibustion – burning of the mugwort/moxa herb on or about an acupuncture point – there will be a layer of burn cream on the skin if the moxa is directly on the point

Cupping – glass or plastic cups are applied with suction to the skin

Electrical Stimulation – an electrical stimulation machine is attached to the needle to provide continual micro-current vibration or a Pachi Pachi instrument provides an electrical spark to the needle or acupuncture point

Tui-Na massage – Chinese massage involving, but not limited to, stretching, range of motion, muscle manipulations and acupressure

Gua Sha – pressured massage strokes on the skin using a smooth edged tool

None of these methods of treatment will be done without being discussed first. I may refuse any of the methods of treatment at any time.

Side Effects: Although acupuncture is a safe method of treatment, one may experience bruising, tingling or numbness near a needling site. One may also experience possible dizziness and/or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture. Burns and scarring are potential risks of moxibustion. Infection is another possible risk, although only disposable sterile needles are used by a licensed practitioner in a clean, safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. If any persistent discomfort persists, I will contact a physician.

Confidentiality: I understand the Corinne Kohrherr, L.Ac. and her staff will keep my records and information confidential. My records will be available to me upon written request and will not be released to others without my written consent.

Release: I do not expect Corinne Kohrherr, L.Ac. to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on Corinne Kohrherr, L.Ac. to exercise judgment during the course of treatment based on my best interest and the facts available. I understand that acupuncture treatments are not always successful and that no guarantee or assurance has been given to me by anyone concerning the results of treatment.

I will notify Corinne Kohrherr, L.Ac. if I become pregnant.

I have not been given a diagnosis of cancer by a physician. If I have been given such a diagnosis or potentially receive such a diagnosis in the future, I will inform Corinne Kohrherr, L.Ac.

I understand that that Corinne Kohrherr, L.Ac. may end the session at any time if any improper conduct occurs on my behalf. If this occurs, I am financially responsible for the entire session.

By voluntarily signing below, I show that I have read or have had read to me, this consent to treatment. I have been told about the risks and benefits of acupuncture and other procedures and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for both the present condition and for any future conditions for which I seek treatment(s). I understand that I have the option to discontinue treatment at any time.

Print Name of Patient

Date Consent Completed

Signature of Patient or Representative

Signature of Corinne Kohrherr, L.Ac.

Print Name of Representative

ADVISORY TO CONSULT PHYSICIAN

It is recommended that you consult a physician regarding any conditions for which you are seeking acupuncture treatment(s).

I, (print name) _____ have been advised by Corinne Kohrherr, L.Ac. to consult a physician regarding the conditions, for which I seek acupuncture treatment(s). I acknowledge that acupuncture and its associated therapies are not a substitute for medical care, medical examinations or medical diagnoses.

Signature of Patient or Representative

Date Advisory Completed

Print Name of Representative

Signature of Corinne Kohrherr, L.Ac.