



Schrage Chiropractic

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 physiotherapy on me (or on the patient named below, for whom I am legally responsible) by the below named licensed Chiropractor and/or other Certified Acupuncture Technologist who now or in the future treats me while employed by, working or associated with or serving as a back-up for the treating Chiropractor named below, including those working at this office or clinic.

I understand that methods or treatment may include, but are not limited to, acupuncture with needles, moxibustion, electrical stimulation of the acupuncture point, or manual stimulation of the acupuncture point.

I have had the opportunity to discuss with the doctor named below and/or with other office or clinic personnel the nature and purpose of acupuncture treatments and other procedures.

Acupuncture attempts to normalize physiological functions, to modify the perception of pain, and to treat certain diseases 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 that last a few days. There have been very rare instances reported of fainting, infection and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon the facts then known, and is in my best interests.

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 written consent.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content.

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.

Name (Printed)

Date Signed

Signature: Patient or Legal Representative (Attorney, Guardian, Parent)

Witness to Patients' Signature

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