10 Falconer Drive, Unit 2, Mississauga, ON L5N 3L8 Phone: 905-997-8337

Informed Consent for Acupuncture Care

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, as necessary, including electro-acupuncture by any duly qualified doctor/therapist of the above mentioned clinic.

I understand and am informed that in the practice of acupuncture there are some risks associated to treatment, including but not limited to bruising, minor bleeding, minor discomfort or soreness, nausea, fainting, and possible perforation of internal organs.

I further state that the following **DO NOT** exist in my current state of health and I will immediately notify the doctor/therapist of any changes as soon as I am of aware of them myself:

***Pregnancy** ***Pacemaker** ***Bleeding Disorders** ***Use of Anticoagulants**

***Elevated Risk of Infection** ***Have or suspected of having HIV, Hepatitis A, B, or C or any other blood disorder that may affect the health of the therapist if he or she were to come in contact with your blood.**

I have been advised that only sterilized one time use only needles will be used during my acupuncture treatment and that they are properly disposed of after they are used.

I expect that the doctor/therapist, if questioned, will be able to answer any of my questions or concerns regarding the use of acupuncture but do not expect that the doctor/therapists will be able to anticipate any or all of risks associated with the use of acupuncture during the treatment process. I rely on the doctor/therapist to exercise judgment during the course of treatment which is felt to be the best treatment course, based on the facts then known and the doctor's/therapist's experience and best and most current scientific research.

I have read the above consent form and have had the opportunity to ask questions about its content, and by signing below I agree to the above-mentioned acupuncture procedures. I intent for this consent form to cover the entire course of treatment by the undersigned doctor/therapist.

Female Patients fully understand that in the case of pregnancy that the risk of fetal distress with acupuncture treatments is possible. I therefore state that I am not pregnant and if I am to try to get pregnant or am currently pregnant that I will immediately inform my treating doctor/therapist.

Read before Signing

Date Signed	**Print Patient's Name**	**Signature of Patient (or/parent/guardian)**
Date Signed	**Therapist's Name**	**Signature of Therapist**