Hillcrest Community Acupuncture

1807 Robinson Avenue, Suite 205, San Diego, CA. 92103 (619) 298-2228

ACUPUNCTURE INFORMATION AND INFORMED CONSENT

I understand that acupuncture involves the insertion of pre-sterilized, disposable needles through the skin at specific points and that additional therapies (such as herbal therapy, nutrition therapy, acupressure, cupping, gua sha, electrical stimulation to the skin, and TDP heat lamp) may be suggested to support the treatment process. All therapies will be explained before administration. Side effects such as local bruising, needle sickness, broken needles, pain at site of insertion, infection, pneumothorax, spontaneous miscarriage, 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 **Hillcrest Community Acupuncture (hereinafter called 'HCA')** does not provide primary care medicine, and that I am responsible to seek primary health care from a qualified Physician. 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 **HCA** may record medical and other information concerning my treatment. I understand that **HCA** 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 _____