PATIENT INFORMATION AND CONSENT

Side Effects and Risks

- Drowsiness can occur after treatment in some patients. If you are affected, you are advised not to drive.
- Minor bruising or bleeding may occur in some patients.
- Pain may occur in some patients during insertion of the needles.
- Heat application poses the risk of burn.
- Existing symptoms may sometimes increase after treatment.
- Fainting may occur in some patients, particularly during the first treatment.
- Movement while needles are in place poses risk of injury.

You are responsible to Inform Your Acupuncturist

- If you have ever experienced dizziness, a fainting spell, a "fit" or "funny turn" in any way
- If you have a pacemaker or any other electrical implants
- If you have a bleeding disorder
- If you have an infectious disease
- If you are taking anti-coagulants/blood thinners, diuretics/water pills, medication for diabetes or high blood pressure and any other prescription or over the counter medications and supplements
- If you have damaged heart valves
- If you have a particular risk of infection or poor immunity
- If you feel dizzy or uncomfortable during treatment
- If you feel drowsy after treatment
- If your existing symptoms get worse after treatment
- If you are pregnant or intend to become pregnant while under the care of your acupuncturist

Statement of Consent

I confirm that I have read and understand the above information. I have had the opportunity to ask questions regarding my treatment. The nature of the procedures and treatments, their risks, benefits and potential side effects have been explained to me. I understand that I may be involved in various intervention techniques, including acupuncture, electrical stimulation, massage, stretching, physical exercises, stress management and lifestyle counseling, relaxation techniques and body movement, and I hereby agree that Lucinda M. Fecteau, PhD, MAOM, OT/L, Renaissance Wellness, Acupuncture and Integrative Medicine Associates of Nashua and all affiliates will not be responsible for any injury that may occur as a result of my participation in these techniques during the treatment process or as a result of the use of these techniques after treatment has been discontinued. I understand that I have the right to refuse any form of treatment. I agree to remain still while receiving heat therapy, while the needles are in place and I agree not to interfere with their placement. I understand that payment is due at time of service and agree to provide at least 24 hours prior notification of an appointment cancelation or I will be responsible for payment of the treatment fee. I request and consent to treatment.

_____ _____ _____

Patient or Guardian Signature | Patient or Guardian Printed Name | Initials

_____/_____/_____ _____

Date | Relationship to Patient