ACUPUNCTURE AND INTEGRATIVE MEDICINE ASSOCIATES OF NASHUA, PLLC
60 Main Street #310, Nashua, NH 03060 | 603.231.2478 | www.aimaofnashua.com

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 damaged heart valves, if you have a bleeding disorder, if you have an infectious disease or if you have a particular risk of infection or poor immunity
- 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 feel dizzy, uncomfortable or drowsy after treatment, or 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 and that 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. Theroux-Jette, PhD, OT/L, LAc, Acupuncture and Integrative Medicine Associates of Nashua PLLC and all employees and 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. In the event of an occupational exposure incident or needle stick injury, I consent to have my blood tested as soon as feasible for HBV, HCV, and HIV, and I authorize disclosure of the results to all individuals involved in the exposure incident or needle stick injury. 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 am aware of the limitations involved in electronic communication including potential breaches of privacy and confidentiality, difficulties in validating the identity of the parties, and delays in responses. I accept these limitations and consent to electronic communication with my health care provider(s) at Acupuncture and Integrative Medicine Associates of Nashua, PLLC. 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 understand that I have the right to refuse any form of treatment.
I request and consent to treatment for (**Print Patient Name**): ______________________________________.

____________________________________	____________________________________
Patient or Guardian **Signature**	Patient or Guardian **Printed Name**
_______/_______/___________	____________________________________
Date	Relationship to Patient (self, guardian, etc.)