****

**INFORMATION AND CONSENT TO TREAT**

**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.
* Discomfort or pain may occur in some patients during insertion of the needles.
* Heat application poses the risk of burn.
* Insertion of needles poses the risk of infection.
* Existing symptoms may sometimes increase after treatment.
* Dizziness or 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, lightheadedness, 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
* 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
* If your existing symptoms get worse after treatment
* If you are pregnant or intend to become pregnant while under the care of your acupuncturist

I understand that I may be involved in various intervention techniques, including but not limited to acupuncture, low level laser therapy, electrical stimulation, heat therapy, cold therapy, massage, cupping, gua sha, stretching, physical exercises and body movement, stress management and relaxation techniques, lifestyle counseling, and nutritional counseling. I understand that I may be prescribed Chinese herbal medicine (medicinals), and that I may need to prepare and consume prescribed medicinals according to the instructions that will be provided orally and in writing. I understand that some medicinals may have an unpleasant odor or taste. I understand that some medicinals may be inappropriate during pregnancy. I understand that the medicinals and nutritional supplements that may be recommended are traditionally considered safe in the practice of Chinese medicine. I understand that some medicinals may be toxic in large doses. Possible side effects of taking medicinals include but are not limited to nausea, gas, stomach ache, vomiting, diarrhea, headache, tingling or numbness of the tongue, and skin rashes or hives. I will immediately notify the prescribing provider if I am pregnant or become pregnant while taking medicinals. I will immediately notify the prescribing provider of any unanticipated or unpleasant effects associated with the consumption of these medicinals. I have been informed that acupuncture is a generally safe method of treatment, and that it may have side effects that could last a few days, including but not limited to discomfort, numbness, or tingling at or near needle insertion sites, bruising, bleeding, symptom exacerbation, and drowsiness. I understand that risks include dizziness and fainting, injury, and infection; burns or scarring are potential risks of moxibustion, cupping, and treatment involving the use of heat lamps; unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ perforation. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I do not expect my provider to be able to anticipate and explain all possible risks and complications of treatment. I do wish to rely on my provider to exercise clinical judgment during the course of my treatment in order to make treatment decisions based upon known facts that are in my best interest. I understand that results are not guaranteed.

I hereby agree that Lucinda 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, HIV, and any other infectious agent, 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 clinicians, students, and administrative assistants may review my records. I understand that payment is due at time of service and agree to provide at least a 24-hour prior notification of an appointment reschedule or cancellation, 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 hereby request and consent to treatment for myself (or for the patient named below, for whom I am legally responsible), by Lucinda M. Theroux-Jette, PhD, OT/L, LAc and by Acupuncture and Integrative Medicine Associates of Nashua, PLLC employees and affiliates, whether or not such parties are signatories to this form.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment for myself or for the patient named below, for whom I am legally responsible. I have been told about and understand the nature of the procedures and treatments, their potential side effects, risks and benefits, and I have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for the present condition, and for any future condition(s) for which treatment is sought.

**Patient Name (PRINT**): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Guardian **Signature**  Patient or Guardian **Printed Name**

\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Relationship to Patient (self, guardian, etc.)