KAISER PERMANENTE®

## Center for Complementary Medicine

HRN Label

# CONSENT FORM FOR ACUPUNCTURE

Acupuncture is an art of healing involving the stimulation of specific points on the body to relieve pain or cure diseases. The stimulation may be produced by needles, heat, digital pressure, and/or electrical currents, but most frequently is done with needles. Acupuncture has been in use for probably 4000 years; it has persisted because of its effectiveness. Although acupuncture has been used in the Orient and in Europe as an authentic therapy, it is still considered an experimental/alternative procedure by many in the United States. The U.S. Food and Drug Administration (FDA) have approved acupuncture needles. We use sterilized stainless steel needles that are used once and then disposed of.

I, ______________________, understand the hazards and potential dangers involved in treatment by means of acupuncture. I believe that this treatment is in my best interest and I understand that no guarantee of results has been made.

I understand and accept the risks of treatment that the acupuncturist has explained to me which include, but are not limited to bruising, bleeding, swelling, fainting, or infection. Minor bruising and bleeding are common and to be expected as the body responds to acupuncture treatment. Certain medications or social habits are known to lessen the potential results of acupuncture. These include alcohol, tobacco, steroids or narcotics. I agree to inform the acupuncturist of any use of these substances.

I understand that it usually requires a series of acupuncture treatments to significantly change a condition and receive benefit.

**My Signature** indicates that I have read and fully understand the above information regarding the consent to this procedure. I have had the opportunity to ask questions about any matter which I did not understand, and I have received satisfactory explanations to my questions. My signature below authorizes this procedure.

______________________________ ______________________________

Patient/Authorized Representative Signature    Relationship to Patient    Date

**Practitioner Statement:** The patient (or patient's representative) and I have discussed this procedure, the risks and alternatives to this procedure. To the best of my knowledge, the patient (or patient's representative) understands this procedure and consents to it.

______________________________ ______________________________

Practitioner Signature    Practitioner Printed Name    Date

**Cancellation Guidelines:**
The staff of the Kaiser Permanente Centers for Complementary Medicine strives to provide excellent service to our patients. In order to do so, please give us a 24-hour notice of cancellation when you are unable to keep a scheduled appointment. We would be happy to reschedule your appointment for you. You could be charged a fee for failure to show for your appointment.

*Initials*__________

**After-hours questions:**
The Kaiser Permanente Centers for Complementary Medicine does not have after-hours availability. If you have general questions about our services, please call the main number for your ***preferred*** location and leave a message. Your call will be returned the next business day. If you are having medical symptoms that need immediate attention, please call your primary care physician or specialty care physician. If you believe it is an emergency, please call 911.

*Initials*__________

**Acknowledgement of Financial Responsibility:**
I understand that I am financially responsible to the Center for Complementary Medicine for services provided if not a covered benefit by my Kaiser Permanente plan. I am also responsible for payment of services at the Center for Complementary Medicine if my employment status has been altered or my insurance terminated.

*Initials*__________

If **Non-Kaiser Permanente member:** ***Primary Care Physician*** and Phone Number ______________________________

Emergency Contact Name and Phone number: ______________________________