



RIVERTOWN ACUPUNCTURE

CONSENT TO TREATMENT

I understand that by voluntarily signing this form, I am consenting to acupuncture treatments and procedures, as defined by Classical Chinese Medicine, to be performed by Randi Marie Hoffmann, L.Ac. I understand that the method of treatment may include but is not limited to acupuncture, acupressure, tui na, moxibustion, cupping, gua sha, electrical stimulation and herbal liniments.

I have been informed that there may be adverse effects to acupuncture which could include but are not limited to local bruising, mild pain in the area treated, sore or aching muscles, brief generalized fatigue, and tingling or numbness. I will notify the acupuncturist who is caring for me if I become pregnant, as I understand that an unusual side effect of some acupuncture points may stimulate spontaneous miscarriage.

I understand that I am encouraged to communicate any discomfort I may feel during the needling process, so that the needles can be adjusted and/or removed. I also understand that there are no guarantees concerning the use of acupuncture and its effects. I have been informed that I am free to stop treatment at any time, as well as being free to refuse modalities that may be offered as part of the treatment.

I understand that I should not change my position or move suddenly while the needles are in place. I understand that it is important for me to maintain good personal hygiene. I understand that I should avoid treatment when excessively fatigued, hungry or full. I understand that I will not be treated if I am intoxicated and/or are abusing substances.

I understand that payment is due upon receipt of services.

By voluntarily signing below, I show that I have read or have had read to me this consent to treatment. I have been told about some of the risks acupuncture and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for both the present condition and for any future conditions for which I seek treatment(s).

Signature of Patient or Patient Representative

Date