

PATIENT INFORMED CONSENT for ACUPUNCTURE

I, _____, hereby voluntarily consent to be treated with acupuncture and/or Chinese Herbs, administered by Claudette Baker or associates, hereinafter referred to as "Practitioner". I understand that acupuncture is performed by the insertion of fine, pre-sterilized, disposable acupuncture needles (with or without the addition of electric current) through the skin, or the application of heat to the skin, or both, at certain points on the body, in an attempt to improve the body function and/or relieve pain.

I acknowledge that, although rare, certain side effects may result from acupuncture. These can include bruising, mild pain or discomfort, a feeling of weakness, fainting, nausea, and a temporary aggravation of symptoms. These effects are unusual and of short duration.

I accept the fact that no guarantee is made concerning the use and effects of acupuncture or Chinese Herbs. I understand that I may stop treatment at any time.

I further understand that the evaluation given me is an energetic assessment of the acupuncture meridian network, and in no way purports to be, or replaces a western medical examination and diagnosis. In the course of the evaluation, there may be reference to the state of various "organs", such as heart, liver, spleen, kidneys, etc., which actually refers to energetic channels of the same name.

I acknowledge the fact that Claudette Baker / Practitioner is not and does not profess to be a western-trained medical doctor and does not use or advise on the use of medically-prescribed pharmaceuticals or medical treatments, nor does Practitioner give any substances by injection.

I acknowledge that Practitioner has completed a minimum of three years training in Acupuncture and Oriental Medicine, is National Board Certified (NCCAOM) and a Licensed Acupuncturist (L.Ac.) in the State of Illinois.

If clinical data is gathered it will be without names and may be used for statistical data and research. We are HIPAA compliant to protect your privacy. According to federal policy, we need your written consent for the following:

Do we have your permission to make appointment confirmation calls? **Yes** or **No**
If yes, what number(s) shall we call?

Home _____ May we leave a message? _____
Cell _____ May we leave a message? _____
Work _____ May we leave a message? _____

Signature: _____ Date: _____ Witnessed by: _____

Patient or guardian

Practitioner

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