



**ASHEVILLE COMMUNITY ACUPUNCTURE**  
**378 HAYWOOD ROAD, ASHEVILLE, NC 28806**  
**CAT FINKS, L.AC.   TODD WALKER, L.AC.   JESS MUND, L.AC.**

**ACUPUNCTURE AND CHINESE MEDICINE**  
**INFORMED CONSENT TO TREATMENT**

The purpose of this form is to present some of the benefits and possible risks associated with Chinese Medical procedures offered at Asheville Community Acupuncture.

By signing below, I do hereby voluntarily consent to be treated with Chinese Medical procedures by a North Carolina State licensed acupuncturist at Asheville Community Acupuncture. I understand that the methods of treatment are aimed at the restoration and maintenance of optimal health and may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui Na (massage), Chinese Herbal medicine, and nutritional counseling. I understand that these methods must be conducted with caution if I am pregnant and I agree to notify my practitioner if I become aware that I am pregnant. I understand that results from the aforementioned treatment methods are not guaranteed and that I am free to discontinue their use at any time. While I do not expect my practitioner to anticipate and explain all possible risks and complications of treatment, I wish to rely upon their competent judgment during the course of treatment based upon a diagnosis which reflects my best interests. I understand that acupuncturists practicing in the state of North Carolina are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by the practitioners here at Asheville Community Acupuncture.

**Acupuncture/ Electrical Stimulation/ Moxibustion/ Heat Lamp Therapy/ Massage/ Cupping:** I understand that acupuncture is performed by the insertion of sterile, disposable needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that I may be given the option to receive electro-acupuncture as a part of my treatment regimen. I am aware that I may be asked to receive moxibustion therapy, which is a form of heat therapy applied to the body via the combustion of a moxibustion agent (typically artemesia vulgaris; mugwort) I have been informed that although these techniques are generally safe methods of treatment, certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, numbness and tingling near the needling points, dizziness, fainting, pain or discomfort, skin and surface burns (from moxibustion & Heat Lamp therapy). Unusual risks include minor electrical shock (from electrical stimulation), organ puncture; including pneumothorax (puncture of Lung), spontaneous miscarriage, nerve damage, and the possible aggravation of symptoms existing prior to acupuncture treatment. Infection is a highly unlikely risk since this clinic uses sterile disposable needles and maintains a clean and safe environment. I understand that I may also choose to receive massage, or cupping (massage technique using glass or plastic cups). I am aware that this therapy may result in minor bruising and/ or sore muscles. I understand that I may stop the therapy if it is too uncomfortable.

**Herbs and Supplements:** I understand that substances (which consist of plant, animal, and mineral substances) from the Materia Medica may be recommended to me for internal or external use to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that these substances are generally safe, though may be toxic in high doses. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, skin irritation, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I will suspend taking them and call my practitioner as soon as possible.*

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that during the course of my treatment I am responsible for communicating my questions, concerns and needs to my practitioner so that I may be supported in the best way possible. I give my permission and consent to treatment for the duration of my sessions here at Asheville Community Acupuncture.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Guardian if client is a minor:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_