Informed Consent for Acupuncture Treatment & Care

I, or my authorized representative on my behalf, hereby request and consent to the performance of acupuncture treatments by Heidi Eimermann MD. I understand that methods or treatment may include, but are not limited to: acupuncture, electrical stimulation, Western herbal medicine, supplement recommendations, and lifestyle counseling.

Acupuncture attempts to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body by inserting fine needles into specific points on the body. Acupuncture is a safe method of treatment, though there may be some bruising or tingling near the needling sites that last a few days. To prevent infection, only single-use, sterile, disposable needles are used in this clinic. Possible risks include but are not limited to fainting, infection, lung or other organ puncture, nerve damage, including spinal cord trauma, local bleeding, swelling and broken needles. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax.

I am also aware that acupuncture may mask an underlying condition or retard a more exact diagnosis. I agree to maintain a relationship with a primary care provider. If Dr Eimermann feels at anytime during treatment that acupuncture is not appropriate for my condition, I will be referred for further evaluation/treatment to either a primary care physician, or if the situation warrants, an Urgent Care or Emergency Room.

I do not expect Dr Eimermann to anticipate and explain all risks and complications. I wish to rely on Dr Eimermann to exercise judgment during the course of treatment. Contraindications for acupuncture include a history of a bleeding disorder or current anticoagulant therapy, implanted pacemaker or prosthetic valve, pregnancy, or seizure disorder. I understand and have informed Dr Eimermann if any of these conditions exist and have provided an accurate medical history to the best of my knowledge.

The procedure(s) and associated risks have been explained to me. I have been told that the procedure may not produce the result that I expect. I confirm that no guarantee of results has been made to me or my representative. I have been told of other treatments for my condition and what may happen if no treatment is received.

I have had adequate time to discuss my condition, treatment, and alternatives with Dr Eimermann. I have read, or have had read to me, the above consent. I have had an opportunity to ask questions about its content and all of my questions have been answered to my satisfaction. I believe I have enough information to make an informed decision regarding treatment.

By signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I may withdraw my consent and stop treatment at any time.

I understand my records will be kept confidential and will not be released without my consent unless necessary to provide emergency care and services, or when required or permitted by law. I have received a copy of the Notice of Privacy Policies.

Patient's Name _____

Patient Representative's Name _____

Patient's/Patient Representative's Signature _____

Today's Date _____/_____/_____