Kristin Lundeen ACUPUNCTURE
2101 Defense Highway, Ste A | Crofton, MD21114
(443)584-3047
www.kristinlundeenacupuncture.com

Voluntary

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/ or other licensed acupuncturists who now or in the future treat me while employed by, working, or associated with or serving as back-up for the acupuncturist name below, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, CranioSacral Therapy, Tui-Na (Chinese Massage), Chinese herbal medicine and nutritional counseling. I understand that herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have not been guaranteed any success concerning the uses and effects of acupuncture. I understand that I am free to discontinue treatment at any time. If I need to cancel an appointment I will do so with at least 24 hours notice. I understand that a cancelling made with less than 24 hours notice is subject to a charge equal to that full fee of a scheduled appointment.

Possible Side Effects/Healing Reactions

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, dizziness, or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Infection is a possible risk, although mitigated by the use of single use, sterile, disposable needles and maintenance of a clean and safe environment. I understand that my practitioner(s) have been trained to practice safe acupuncture in order to minimize these risks as much possible.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses I understand that some herbs may be inappropriate during pregnancy. Some possible side effect of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

Initial: _____

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Conventional medical therapy may be recommended in conjunction with your acupuncture treatments, either in response to an emergency or as deemed necessary at the discretion of a licensed physician. I understand that acupuncture treatment may cause a drop in blood sugar levels for patients with diabetes. Monitoring and adjusting medication to control blood sugar levels is the responsibility of the patient and their licensed physician.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

Medical Referral

I understand that if there is worsening of my ailment or condition, or if it does not improve within the time estimated by the acupuncturist at the beginning of treatment, or if a new ailment or condition arises, I should consult a licensed physician.

Infectious Disease/Clean Needle Procedures

I understand that infectious disease is carried through the air, through physical contact, and through body fluids. I understand that Kristin Lundeen follows universally prescribed precautions to guard against the spread of infections. In the case of airborne infectious diseases, such as cold and influenza, I understand that practitioners are urged not to see patients until they are well. In the case of infectious disease spread by physical contact such as small box, I understand that practitioners wash their hands before seeing each patient to guard against contagion by contact. Surgical gloves or finger cots are also available for this purpose. In the case of blood-borne infections, such as hepatitis or HIV, I understand that Kristin Lundeen follows strict precautions. Practitioners use only sterilized prepackaged, disposable needles. I understand that my questions about the safety of acupuncture and the precautions taken by the practitioner are most welcome and will be answered as fully as possible.

By voluntarily signing below, I acknowledge that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had the opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any condition(s) for which I seek treatment.

ACUPUNCTURIST NAME: Kristin Lundeen

PATIENT SIGNATURE:
(or patient representative; indicate relationship is signing for patient.)

_____ Date: _____

Initial: _____