**Consent Form for Receiving Acupuncture**

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**Name of Practitioner (Recipient)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**License Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Phone / Email**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Patient/Individual Performing Acupuncture**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose of This Consent**

I, the undersigned, give my informed consent to receive acupuncture treatment from the above-named licensed acupuncturist, employed by Turtle Acupuncture. I understand that acupuncture is a component of Traditional Chinese Medicine (TCM) and is used for the diagnosis, treatment, and prevention of disease and for the promotion of health and well-being.

**Description of Procedure**

I understand that acupuncture involves the insertion of fine, sterile, single-use needles into specific points on the body to influence the flow of Qi, promote balance among the organs, and regulate physiological functions in accordance with the principles of Traditional Chinese Medicine.

Techniques that may be used during treatment include:

* Manual needle stimulation
* Electro-acupuncture
* Moxibustion (heat therapy)
* Cupping
* Gua Sha
* Tuina (manual therapy)

The practitioner will explain the specific methods used during each session.

**Potential Risks and Side Effects**

While acupuncture is generally considered safe when performed by trained professionals, I acknowledge that possible side effects may include:

* Temporary soreness or discomfort at the needle site
* Minor bleeding or bruising
* Fatigue or lightheadedness
* Rare risk of infection or injury
* Exacerbation of symptoms in rare cases as part of a healing process

I understand that all procedures will be performed with sterile, single-use needles and in accordance with hygienic clinical standards.

**Confidentiality and Privacy**

All personal and medical information shared with the practitioner will remain strictly confidential and will not be disclosed without my written consent, except as required by law.

**Voluntary Consent and Right to Withdraw**

I understand that participation in acupuncture treatment is entirely voluntary. I may refuse any specific technique or withdraw from treatment at any time without affecting my right to future care at Turtle Acupuncture.

**Questions and Understanding**

I affirm that:

* I have had the opportunity to ask questions about acupuncture treatment.
* I have received answers to my satisfaction.
* I understand the nature, purpose, potential benefits, and risks of acupuncture.
* I give my full and informed consent to proceed with treatment.

**Signatures**

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

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

**Witness (optional)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_