Consent for Acupuncture, Cupping and Moxibustion Therapies

**Acupuncture:** includes the insertion of sterile disposable needles at points on the body indicated by the methods of diagnosis. Heat lamps and/or mild electric stimulation may be applied to the needles during the acupuncture treatment. **Moxibustion:** a procedure using a burning herb to warm specific points may also be applied. **Cupping:** a suction therapy applied to the skin may be used to stimulate tissue stagnation.

Acupuncture, moxibustion and cupping are all Oriental Medicine therapies.

I understand that Oriental Medicine therapies in the state of Arizona are not a primary health care modality. I understand that seeing an acupuncturist for Oriental Medicine therapies at SCNM Medical Center does not replace seeing my primary care physician. I understand that, if I am referred by my primary care physician for Oriental Medicine therapy, I will return to my primary care physician for follow-up as needed. If my practitioner is a naturopathic doctor, they may act, at my request, as my primary care physician who is also licensed to perform Oriental Medicine therapies.

I will inform my practitioner if I am pregnant, have a cardiac pacemaker or other implanted electronic device or skin condition that may contraindicate acupuncture as a treatment therapy.

**The Benefits:**
I understand that I will be receiving Oriental Medicine therapies for the treatment of my health condition. I understand that the potential benefits of Oriental Medicine therapies include drugless relief of my symptoms and an improved state of health.

**The Risks**
- Pain at site of insertion
- Local bruising
- Fainting or dizziness
- Broken needles
- Local infection
- Collapsed lung if needling in near the lungs
- Spontaneous miscarriage

**Alternatives to Oriental Medicine Therapies**
There are reasonable alternatives to Oriental Medicine therapies including self-administered over-the-counter analgesics, rest, prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers, hospitalization and surgery. These alternatives have been reviewed with me by my provider.

I have read this Consent Form and have had my questions answered about potential benefits, risks and alternatives to my satisfaction and consent to treatment.

_________________________________  ______________________________
Signature  Date

_________________________________
Printed Name

Relationship (self, parent, legal guardian, personal representative, etc.)