Acupuncture Informed Consent to Treat

Jennifer Luan, MD

Princeton Medical Acupuncture Center, LLC

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 Jennifer Luan, MD

I understand that methods of treatment may include, but are not limited to acupuncture, electrical stimulation.

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, and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including ling puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

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

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.

By voluntarily signing below, I show 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 an opportunity to ask questions. I intend this consent for to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Acupuncturist Name: Jennifer Luan, MD

Patient Name (Or Patient Representative): _____

Date and Signature: _____