NEW WAY ACUPUNCTURE LLC
ACUPUNCTURE INFORMED CONSENT TO TREAT

3355 St. John"s Ln. Ellicott City MD 21043 T:301-818-9191

1. **Purpose of Treatment**

I understand that acupuncture is a traditional healthcare method used to support pain relief, improve function, and promote general wellness. It is not a substitute for medical diagnosis or treatment by a physician.

2. **Treatment Methods**

I consent to acupuncture and related therapies including:
• Acupuncture (sterile needle insertion) • Moxibustion • Cupping Therapy
• Electrical Stimulation • Chinese Herbal Medicine • Tui-na (Medical Massage)

3. **Potential Benefits**

Possible benefits may include pain reduction, improved sleep, reduced stress, and improved physical function. Results vary between individuals.

4. **Risks and Side Effects**

Common risks include bruising, minor bleeding, soreness, dizziness, or lightheadedness.
Rare risks include infection, nerve injury, or organ puncture, including pneumothorax.

5. **Herbal Medicine Risks**

Herbal medicine may cause allergic reactions, digestive upset, or other side effects depending on individual conditions.

6. **No Guarantee**

No guarantee has been made regarding specific results or cure.

7. **Medical Disclosure**

I agree to provide complete and accurate information regarding my medical history, medications, allergies, and pregnancy status.

8. **Alternatives**

Alternatives include medical treatment, physical therapy, medications, or no treatment.

9. **Voluntary Consent**

I understand that I may refuse or discontinue treatment at any time.

10. **Sterile Needles**

I understand that only sterile, single-use disposable needles are used during treatment.

11. **Electrical Stimulation Notice**

I agree to inform the practitioner if I have a pacemaker, seizure disorder, implanted medical device, or any condition that may affect the use of electrical stimulation therapy.

12. **Patient Acknowledgement**

I have read and understand this consent form. I have had the opportunity to ask questions regarding the treatment and all questions have been answered to my satisfaction.
PATIENT CONSENT AND SIGNATURE

PatientName_____

Signature._____Date_____/_____/_____