

Wagner Integrative Therapies
875 N. Easton Rd., Ste 5B
Doylestown, Pa 18902

Informed Consent Document For ACUPUNCTURE

• I, _____, voluntarily consent to be treated with Acupuncture administered by Jean-Paul Rouzier, L.Ac. (Please initial each below)

• I understand that the Acupuncture will be performed by the insertion of sterile disposable needles through the skin, or by the application of cupping, cold laser, or by some combination of the foregoing, at certain points on my body. _____

• I understand that although rare, certain side-effects may result from my acupuncture treatment. These could include some minor discomfort, fainting, nausea, localized bruising, or the temporary aggravation of preexisting conditions. _____

• I accept that no guarantee is made concerning the results of my Acupuncture treatments and that I am free to stop treatment at any time. _____

• I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure, based upon the facts then known. _____

• I have read, or have had read to me, this consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek acupuncture treatment.

• I, the undersigned, do affirm that I have been advised by the acupuncturist to consult my physician regarding the condition(s) for which I seek acupuncture treatment. _____

Date: _____

Patient's Name

Patient's Signature

Signature of Parent or Guardian (if patient is a minor)

Doctor's Name

Doctor's Signature