# Acupoint Trigger Point Injection Therapy
# Consent Form

Traditional Chinese Medicine has been used for over 2,500 years and is a very safe, natural and effective way of preventing disease as well as treating acute and chronic health issues. Acupuncturists observe the whole person, body, mind and spirit to assess, diagnose and treat each individual patient. A Registered Acupuncturist has in-depth training in TCM medical theory and diagnosis, acupuncture trigger point injection therapy for multiple locations and needling techniques and will provide you with the best benefits of acupuncture.

☐ I understand that I must inform my Acupuncturist immediately of any disease process that I may be suffering from, if I am on any medication or over the counter drugs, if I am pregnant or suspect I may be pregnant.

☐ I understand that injections may vary, depending on the problem or need. I give my permission for injections to be administered as deemed appropriate for my condition. I acknowledge that I have the right to discontinue treatment at any time, however symptoms and problems may return. I acknowledge that I have been given the opportunity to discuss the nature and purpose of the treatment; alternate methods of treatment; and the risks, complications and consequences associated with the administration of injections. I further acknowledge that any questions I have regarding the procedure have been answered to my satisfaction and that I have been further told that any additional questions I may have will be answered.

☐ I understand that all injection treatments are accompanied by possible risks. I understand that in all injection therapies, including Biopuncture Vitamin Injections and Acu Trigger Points Pain Injections there is a possibility of bruising, blood spots at insertion sites, temporary increase in pain, flare ups, inflammation, infection, allergic reaction, numbness, nausea, weakness or paralysis, spinal headache or lung puncture as a result of, or in relation to the injections.

☐ I understand that during trigger point injection treatments involuntary muscle twitches can occur, these are a good sign that the muscle fibres are releasing.

☐ I understand that my identity will be protected at all times and, if necessary, identifying information will be altered to protect my privacy. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless law requires it. I understand that the Acupuncturist at this clinic are legally obligated to supersede confidentiality if they become aware of current child abuse or neglect, threats to harm or kill another individual and serious threat of suicide involved with my case. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that fees are payable at the time of appointment.

***I understand that 24 hours notice is required for appointment cancellation; otherwise I will be responsible for the cancellation fee.***

I understand that the results are not guaranteed. I do not expect the Acupuncturist will be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to the therapeutic procedures mentioned above.

I intend this consent form to cover the entire course of treatment with this Acupuncturist. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name: (Please Print) _____

Name of guardian if patient is a child: _____

Signature of Patient (or Guardian): _____

Date: _____

*Optional Consent (please initial box*)

☐ I hereby give my consent to share my file and/or my medical history and current treatment plan options with any other practitioner that I am currently seeing (or may be referred to in the future) at Acacia Integrative Health Clinic for the sole purpose of improving my current health condition and/or to discuss current and/or future treatment options.

Acupuncturist Signature: _____

Date: _____