Eva Stanley Acupuncture

1120 W. South Boulder Road, Ste 201-E, Lafayette, CO 80026 | www.evastanley.com | 1502evastan@gmail.com | (970) 808- EASE (3273)

Informed Consent Statement

My signature authorizes Eva Stanley Dipl. Ac. to treat me (or the patient for whom I am legally responsible) with Acupuncture and Medicinal herbs within the licensure granted by the National Certification Commission of Acupuncture and Oriental Medicine.

☐ **I Agree** I understand that methods of treatment may include, but limited to, homeopathic injection therapy, avatar machine, moxibustion, cupping, electrical stimulation, Tui-Na (Oriental Massage), Oriental herbal medicine, nutritional supplements, and homeopathy. I understand that any above-prescribed medicines are to be taken according to the instructions provide orally or in writing. They may have an unpleasant smell or taste. The herbs, nutritional supplements and/or homeopathic remedies (all of which are from plant, animal and/or mineral sources) that have been recommended are traditionally considered safe, although some may be toxic in large doses. Some possible side effects of taking these medicines are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, tingling, of the tongue and/or worsening of symptoms. **I will stop taking the medicine if any of these side effects occur, and will immediately notify my practitioner of any unanticipated or unpleasant effects associated with the consumption of such medicines.** I understand that some medicines may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am or become pregnant. These medicines are intended only for the person for whom they are prescribed. Do not give these medicines to anyone else.

☐ **I Agree** I have been informed that acupuncture and/or homeopathic injections are generally safe methods 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. Sometimes after receiving an acupuncture treatment, you may feel a little lightheaded. If that is the case, please sit for a while in the waiting room. In a few minutes, you'll feel relaxed and clear-headed. Occasionally, you may get a small hematoma (a small dime-sized bruise under the skin) from either acupuncture and/or injections. This is not a cause for concern - it will go away in a few days. Gentle pressure applied to the site will stop any small amount of bleeding that is occurring under the skin. Bruising is a common side effect of cupping. Unusual, but possible risks of acupuncture and/or injections include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax) and death. Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. Eva H. Stanley, Diplomat in Acupuncture, cannot be held liable for any complications.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on the clinical staff to exercise their best judgment during the course of the treatment that they have prescribed for me. The course of treatment will be based upon the facts known at that time to be 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 that this consent form is to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient (Print Name) _____

Patient Signature _____ **Date** _____