Stefanie Rothert LAc.
Acupuncture for Balance & Transformation

Informed Consent

I hereby consent to acupuncture treatments and related procedures associated with Oriental Medicine, Stefanie Rothert, L.Ac. I understand that the methods of treatment may include but are not limited to acupuncture, facial acupuncture, moxabustion, cupping, gua sha, Tui-Na, electrical stimulation, Chinese herbology, Acutonis, shoni shin and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, however it may have minor side effects, including bruising, numbness or tingling near the needling sites which may last a few days, and in rare cases, dizziness or fainting. This facility only uses sterile, disposable needles and maintains a clean and safe environment. Burns and scarring are potential risks of moxabustion. Bruising is a common side effect of cupping and gua sha treatment, and may last a few days to a week. Although rare and uncommon, there have been cases reported of nerve damage, organ puncture, including lung puncture (pneumothorax) and spontaneous miscarriages. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I understand that there are some acupuncture points and chinese herbs that are inappropriate during pregnancy. I will notify the acupuncturist should I become pregnant or if I am trying to become pregnant.

The herbs and nutritional supplements (which are from plant, mineral, and animal sources) that are used are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. If I experience any gastrointestinal upset, headache, rashes or allergic reactions or any unpleasant side effects from the herbs I will stop taking them and immediately inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on the acupuncturist to exercise judgment during the course of treatment, and decide what she thinks is in my best interest, based upon the facts that are known at the time. I understand the practitioner and administrative staff may review my medical records and reports, but all of my records will be kept confidential and will not be released without my written consent or official court subpoena.

By voluntarily signing below, I show that I have read and understand this consent to treatment and that I have read and understand the Colorado Mandatory Disclosure form. I have been informed about the risks and benefits of acupuncture and other procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Cancellation Policy: I agree to cancel my appointment before 24 hours, if not I am liable for the full service fee. Of course reasonable circumstances do not apply.

_____ _____
Signature of Patient or Patient's Legal Representative Date

Permission to Treat a Minor:
I have read the risks of Acupuncture above and consent to the treatment of the minor that I am legally responsible for.

_____
Guardian's Name RIelationship Signature

_____
Patient's Name Age Date