Acupuncture 4 Your Health LLC (A4YH)
Shu-Chin Hwang, Licensed Acupuncturist (L.Ac)
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Informed Consent and Privacy Policy

Acupuncture" means the stimulation of a certain point or points near the surface of the body by the insertion of special needles. The purpose of acupuncture is to prevent or modify the perception of pain and is thus a form of pain control. In addition, through the normalization of physiological functions, it may also serve in the treatment of certain diseases or dysfunctions of the body. Acupuncture includes the techniques of electro-acupuncture (the therapeutic use of weak electric currents at acupuncture points), mechanical, moxibustion (the therapeutic use of thermal stimulus at acupuncture points by burning Artemisia alone or Artemisia formulations), and blood-letting (the use of lancet or three-edge needle to let out a small amount of blood).

I hereby request and consent to the acupuncture treatments by Shu-Chin Hwang, L.Ac.

I understand that acupuncture is generally a very safe method of treatment with few, but some possible side effects, including slight pain or discomfort at the site of needle insertion, infection, bruises, weakness, dizziness, fainting, nausea, and aggravation of problematic systems existing prior to acupuncture treatment. Bruising is a common side effect of cupping and Gua Sha. Moxabustion and the use of heat therapies may in rare instances cause burning or scarring. I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications and I understand results cannot be guaranteed.
The potential benefits: acupuncture may allow for the painless relief of one's symptoms without the need for drugs, and improve balance of bodily energies leading to the prevention of illness, or the elimination of the presenting problem.

I understand all my patient records will be kept confidential and will not be released without my written consent. I also understand A4YH will from time to time send me information via mail or e-mail including but not limited to receipts, newsletters and office announcements, but that my name and contact information will never be released to any other business or organization. I have been notified that the full A4YH Privacy Policy.

By voluntarily signing below, I show that I have read, or have read to me, the above consent to treatment, have been told about the benefits and risks of the above procedures, and have had an opportunity to ask questions. 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 treatment.

_____
Patient's Printed Name

_____ _____
Patient Signature Date Office Signature (Shu-Chin Hwang) Date