NORFOLK CHIROPRACTIC
WELLNESS CENTRE

INFORMED CONSENT TO ACUPUNCTURE

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, including electro-acupuncture, as necessary, by:

❑ Dr. Dean MacDonald B.Sc., D.C. ❑ Dr. Lori Jones B.Sc., D.C.

I understand and am informed that in the practice of acupuncture, as in all health care procedures, there are some slight risks to treatment, including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting (shock), stuck or bent needles, and in very rare cases, minor perforation of internal organs.

I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest. I also understand that results are not guaranteed.

I have been advised that only pre-sterilized, disposable needles will be used and will be properly disposed after each and every treatment

Note to Female Patients:
I understand that in the case of pregnancy, a risk of causing fetal distress or premature labour with acupuncture treatments is possible.

I have read the above consent and have had an opportunity to ask questions about its content. By signing below, I agree to the above-mentioned acupuncture procedures. I intend this consent form to cover my entire course of care for my present and future conditions for which I choose to seek treatment.

TO BE COMPLETED BY PATIENT:

_____ _____
PRINT PATIENT'S FULL NAME SIGNATURE OF PATIENT
(OR PARENT/GUARDIAN)

_____ _____
DOCTOR'S SIGNATURE DATE SIGNED