Community Acupuncture of Towson
320 E Towsontown Blvd., Towson, MD 21286
443-275-2050
www.catowson.com

ACUPUNCTURE INFORMATION AND INFORMED CONSENT

I understand that acupuncture involves the insertion of sterilized, disposable needles through the skin at specific points and that herbal therapy may be suggested to support the treatment process. All therapies will be fully explained before administration. Side effects such as local bruising, needle sickness, broken needles, pain at the site of insertion, infection, pneumothorax, spontaneous miscarriage, and allergic reaction (with herbs) are rare but possible.

If I agree to take herbal medicine, I understand that I must follow all administration and dosage instructions. I understand that my practitioner is providing dietary guidance based on Asian medicine principles of nutrition and is not a licensed dietician. During the course of treatment, I agree to inform my practitioner immediately if I experience any problem which I associate with the treatments listed above and will go immediately to the hospital if I experience a medical emergency. I understand that acupuncturists practicing in Maryland are not primary care providers and that treatment alternatives may be available from a physician. Physician care is recommended. I consent to receive the therapies listed above, understand the risks and understand that I may refuse any treatment at any time.

I understand that the practice of Acupuncture and Oriental medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment. I understand that acupuncture is conducted in a group setting at Community Acupuncture of Towson. I understand that my conversations in the group room may be overheard by others sitting nearby. I understand that if I need to have a private conversation with the acupuncturist, it is best to do so by telephone, by email, or by scheduling an appointment to talk privately.

I understand that Community Acupuncture of Towson may record medical and other information concerning my treatment. I understand that Community Acupuncture of Towson abides by federal regulations regarding patient privacy as defined under 45 CFR 164.528. I know that I can ask for more information regarding this procedure.

I permit a copy of this authorization to be used in place of the original. This authorization is not intended to allow the release of records regarding my treatment for services requiring a restricted release under State or Federal Law.

Patient's Printed Name:_____

Patient's Signature: _____ Date: _____

Witness Signature:_____ Date: _____

CONSENT TO TREAT A MINOR CHILD

As the parent/guardian of _____, I authorize Community Acupuncture of Towson to administer Acupuncture as deemed necessary. I agree to be present at the clinic for the duration of the minor child's treatment session.

Adult's Signature:_____ Date: _____

Witness Signature:_____ Date: _____