___________________________________ ______/_______/_______

Printed Name Date of Birth

Acupuncture Informed Consent to Treat

Michael Kalsman, M.D. PLLC

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Michael Kalsman, M.D.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Chinese herbal medicine, and nutritional counseling. I will immediately notify Dr. Kalsman of any unanticipated or unpleasant effects associated with the consumption of herbs or acupuncture therapy.

I have been informed that acupuncture is a generally safe method of treatment but that it may have some side effects including bruising, numbness or tingling near the needle sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture. Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

In addition, I understand that although a medical doctor, Dr. Kalsman will only provide acupuncture related services for conditions that can reasonably be treated with such. Any and all medical services, including diagnostic and treatment, will be provided by my own primary care provider; and although Dr Kalsman may recommend discussing certain issues with my primary medical provider, he is not responsible in any way for my medical therapy.

I understand that while this document describes the major risks of treatment, other side effects may occur. Herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of integrative medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify Dr Kalsman if I am or become pregnant.

I will provide all requested medical information to the best of my ability and rely on Dr Kalsman to exercise his best judgment during the course of treatment based on the information given. I understand that results are not guaranteed.

I understand that clinical and administrative staff may review my patient records, 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 a 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.

____ ________________

Signature (relationship if signing for patient) Date