

**Alpine Acupuncture, LLC**

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**Steven A. Foster-Wexler, LAc**

Licensed Acupuncturist, Certified Qigong Instructor  
State License #AC00762  
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**WELCOME!**

Thank you for choosing Alpine Acupuncture, LLC for your health care needs. The purpose of Alpine Acupuncture, LLC is to work together with each individual in achieving their optimum health. We look forward to resolving your health concerns and providing for your health needs, emphasizing health maintenance and preventative care. Oriental Medicine, which includes Acupuncture, Chinese Herbal Medicine, Tuina (Chinese therapeutic massage), Qigong (Chinese exercise therapy), and Chinese Dietary Counseling, offers an approach that both may differ while being complimentary to other forms of medicine. We refer to and work closely with physicians, medical specialists, and other complimentary practitioners to accomplish our stated purpose.

**ACUPUNCTURE INFORMED CONSENT TO TREAT**

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of Acupuncture and Oriental Medicine on me (or on the patient named below, for whom I am legally responsible) by Steven A. Foster-Wexler, LAc and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, TuiNa (Chinese therapeutic massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some adverse side effects, including bruising, numbness or tingling near the needling 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. Transient therapeutic bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, 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 the 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 conditions(s) for which I seek treatment.

ACUPUNCTURIST NAME: Steven A. Foster-Wexler, LAc

PATIENT SIGNATURE **X**

(Or Patient Representative)

(Date)

(Indicate relationship if signing for patient)