

Brielle Acupuncture Center

Consent for Treatment

Acupuncture:

1. I do voluntarily consent to be treated by acupuncture. The procedures involved in this treatment have been explained to me. I understand that I may be treated with the insertion of needles, the application of heat to the skin, a scraping or cupping technique, massage, herbal remedies, or nutritional/lifestyle recommendations. I have not been guaranteed any success concerning the uses and effects of acupuncture. I understand that I am free to discontinue treatment at any time.
2. I understand that my acupuncture practitioner is certified to practice acupuncture in the state of New Jersey. I understand that she is not a physician. As there are certain situations that are best handled by medical doctors, I understand that she may request that I see a physician at some point in my treatment. If there is a worsening of my ailment or condition, or if a new condition arises, I should consult a licensed physician.
3. I have been advised that acupuncture may result in certain side effects, including but not limited to local bruising, slight bleeding, fainting, temporary pain or discomfort, and temporary aggravation of symptoms existing prior to treatment. Conventional medical therapy may be used in an emergency.
4. I understand that Brielle Acupuncture Center, LLC follows universally prescribed precautions to guard against the spread of infection. I understand that only sterile, prepackaged, disposable needles are used. Needles are inserted according to clean needle procedures based on nationally prescribed standards.
5. I have informed Brielle Acupuncture Center, LLC of all my known physical conditions, medical conditions and medications. I will keep them informed of any changes.
6. **Please Note:** A physician referral is not required in order to receive acupuncture treatments, however your insurance carrier may require a referral, letter of medical necessity, and/or preauthorization in order to receive applicable benefits. Your carrier may also require a written diagnosis/diagnosis code from your physician. It is recommended that you contact your carrier before your visit for an explanation of benefits.

Patient Signature

Date

Patient Printed Name

Massage Therapy

1. I do voluntarily agree to be treated by massage therapy/body work. The procedures involved in this treatment have been explained to me. I understand that massage therapy/body work is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, and to improve circulation.
2. I understand all massage therapists at Brielle Acupuncture Center, LLC are certified to practice massage therapy/body work. I understand that my therapist is not a physician. As there are certain situations that are best handled by medical doctors, I understand that she may request that I see a physician at some point in my treatment. If there is a worsening of my ailment or condition, or if a new condition arises, I should consult a licensed physician.
3. I have been advised that massage therapy/body work may result in certain side effects, including but not limited to muscle soreness, local bruising, temporary pain or discomfort, and temporary aggravation of symptoms existing prior to treatment. Conventional medical therapy may be used in an emergency.
4. I understand that massage therapy/body work can, on occasion, stimulate an emotional release.
5. I have informed Brielle Acupuncture Center, LLC of all my known physical conditions, medical conditions and medications. I will keep them informed of any changes.

Patient Signature

Date

Patient Printed Name