LeadingEdge Chiropractic & Acupuncture, P.C.

ACUPUNCTURE INFORMED CONSENT

Consent. I, _____ hereby authorize
(Insert Name of Patient)
_____Dr. Nicole Roemen_____, a licensed acupuncturist, to perform treatment according to the professional standards of the Acupuncture Practice Act of the South Dakota Board of Medical Practice. This authority shall extend to remedying any unforeseen conditions or reactions to treatment procedures.

Practitioner Profile. Please refer to the clinic's Website where Practitioner Profiles are provided. These profiles include information regarding educational training, state licensure, national certification and other professional credentials of clinic practitioners.

Scope of Practice, As stated in the Acupuncture Practice Act of the South Dakota board of Medical Practice, I understand that the scope of practice includes, but is not limited to, the following:

- Using Oriental medical theory to assess, diagnose and develop a plan to treat a patient in an attempt to improve overall body function and/or to relieve pain
- Using treatment techniques that may include:
    - o Insertion of sterile acupuncture needles through the skin
    - o Acupuncture stimulation including, but not limited to, electrical stimulation or the application of heat with moxibustion or heat lamps
    - o Cupping
    - o Dermal friction
    - o Acupressure
    - o Herbal therapies
    - o Dietary counseling based on traditional Chinese medical principles
    - o Breathing techniques or exercise according to Oriental medical principles

Possible Side Effects. I understand that there are possible side effects to my treatment that may include the following:

- Minor pain or soreness in the treatment area
- Transient bruising
- Infection
- Needle sickness (dizziness, nausea, fainting)
- Broken needles
- Sensations of heat, cold, tingling or numbness
- Skin irritation or slight bleeding at needle site
- Generalized fatigue
- Gastrointestinal disturbance from herbal remedies
- Minor burns from moxibustion (heat stimulation)

Treatment Outcomes. I understand that no promises or guarantees can be made regarding the outcome of treatment and that reasonable efforts will be made to give me information so that I might make educated decisions regarding the duration and appropriateness of continued care. I understand that I may stop treatment at any time.

Student Observation. I understand that this site is a teaching clinic and that student observers may be present and may assist during treatment.

Western Biomedical Diagnosis. I understand that it is not within the scope of practice for acupuncturists to offer Western medical (biomedical) diagnosis and that it is my responsibility to seek such diagnosis elsewhere if I have not already done so.

I **have / have not** (circle one) been examined by a licensed physician or other licensed health care provider with regard to my illness or injury. If yes, I have informed the practitioner of the diagnosis.

I **do / do not** (circle one) have a pacemaker or bleeding disorder.

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_____ _____

Patient (or Guardian) Signature Date

_____ _____

Witness Date