Acu-Care
MOBILE ACUPUNCTURE SERVICES

INFORMED CONSENT AND DISCLOSURE

Kimberly Hoover, L.Ac. (530) 575-5620 acucaresd@gmail.com

I hereby consent to acupuncture treatment and/or herbal supplement recommendations for me (or my legal charge) by the acupuncturist named above. I understand that she will explain all known risks and complications, and I wish to rely on her to exercise judgment during the course of the procedure which she determines is in my best interests.

Kimberly Hoover, L.Ac. has discussed with me the procedures listed below that may be used in my treatment. I have read the information below and understand the possible risks involved. I agree to the use of the following procedures if indicated in my treatment:

Acupuncture is a safe and effective method of treatment. However, it can occasionally cause slight bleeding that usually resolves with pressing dry cotton on the spot where the skin is bleeding. It is also normal for the patient to have a temporary warm, tight, sore or tingling sensation at the acupuncture site.

Acupressure requires rubbing, kneading, pressing and stroking, etc., which may result in muscle soreness at the treatment site that can last several days. This technique may require the removal of clothing. I understand all attempts will be made to assure my privacy.

Moxibustion involves burning an herbal material near the skin or on an acupuncture needle. Every precaution is taken to prevent skin contact, but the possibility of skin contact and mild burns exists.

Cupping is a localized suction produced by heating a small glass or or plastic cup. There is a possibility of local bruising from the suction and slight burning or blistering due to the heat involved in the technique.

Electrical Stimulation uses micro current electricity to stimulate acupuncture points. A mild tingling sensation of electricity will be felt.

I have read, or have had read to me, the above consent, and I have had the opportunity to ask questions and discuss this with the provider named above. I consent to treatment that involves the above procedures for my present condition (s) and any future conditions. I have the right to refuse or discontinue any treatment at any time and understand that this refusal may affect the expected results.

Authorization for Release of Medical Information: I further understand that the provider named above may need to contact my medical physician if she has determined that my condition needs to be co-managed with my medical doctors. This coordination of care intends to manage my health condition in my best interest and assure the optimal outcome of my acupuncture treatments. Therefore, I give my authorization to the above provider to contact my medical physician if/when necessary.

Treatment of Pediatric Patients: If the patient is under the age of 3, I understand that treatment of young children has some risk and may need to be coordinated with the child's physician. If I am signing for my child under 18 years old, I give my authorization for the above named provider to perform treatment. She may also contact my child's medical doctor if/when necessary.

Patients's name_____Patient's signature_____Date_____