

Informed Consent Form for Chiropractic and/or Acupuncture

I, _____ hereby authorize **Enlighten Chiropractic & Acupuncture, Dr.**
(Print Name)

Vandara Mounarath and staff to conduct examinations, chiropractic adjustments, acupuncture treatments and other procedures as deemed necessary, including but not limited to various modalities of physiotherapy, soft-tissue techniques, cupping, tui-na, and electro-acupuncture on me or on the patient named above and below, for whom I am legally responsible.

I understand that, as in the practice of medicine, in the practice of chiropractic and acupuncture, there are some risks to treatment. I do not expect the staff of Enlighten Chiropractic & Acupuncture and its affiliates to be able to anticipate and explain all risks and complications. I wish to rely on the practitioner and/or her staff to exercise judgment during the course of the procedures which she feels at the time, based on the fact then known, are in my best interests. I recognize the potential risks of chiropractic & acupuncture procedures as described below:

Acupuncture Potential Risks: Discomfort, pain, bruising, blistering, bleeding, infection at the site of the procedure, temporary discoloration of the skin, possible aggravation of symptoms existing prior to the acupuncture treatment, nerve pain, pneumothorax, puncture of other organs, appearance of new symptoms, and general aches. **Patients with bleeding disorders, HIV, Hepatitis or pacemakers should inform the practitioner prior to receiving treatment.**

Chiropractic Potential Risks: May include but are not limited to, fractures, disc injuries, strokes, dislocations and sprains, soft tissue injury, soreness, general aches, and nerve pain. There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic adjustments: I understand that chiropractic adjustments are the moving of bones with the physicians' hands or with the use of a machine or a drop table.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat/smoke to the skin (or both) at certain points near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time. I understand that I may be asked to have electro-acupuncture administered with acupuncture. I understand that there may be other treatment alternatives, including treatment offered by a licensing physician.

I have had an opportunity to discuss with the doctor of chiropractic and/or acupuncturist and/or with other office or clinic personnel the nature and purpose of chiropractic and acupuncture related procedures. I understand that results are not guaranteed.

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the staff of Enlighten Chiropractic & Acupuncture and its affiliates to perform such procedures. I intend this consent form to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.

Print Patient Name: _____

Patient/Guardian Signature: _____ **Date:** _____

Witness: _____ **Date:** _____