Innovative
Healing Center
Acupuncture • Massage • Nutrition

# TREATMENT CONSENT FORM

I, hereby request and consent to the performance of acupuncture, medical massage therapy, and other procedures including various modes of physical therapy such as tens electrical stimulation, infrared heat lamp, and ultrasound on me (or on the patient named below, for whom I am legally responsible) by the medical practitioner named below and/or other doctors, licensed acupuncturists and therapists, who now or in the future work at the clinic or office listed below.

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

I understand and am informed that, as in the practice of acupuncture and other mentioned therapies there are minor risks to treatment, including but not limited to bruising, tenderness or soreness after treatment, and in extremely rare cases organ puncture. I wish to rely upon the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content and by signing below agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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