Informed Consent

I, _____ have sought acupuncture services from Sleepy Hollow Acupuncture, LLC and acknowledge that **I HAVE BEEN ADVISED TO SEEK MEDICAL SERVICES FROM AN M.D. FOR THE CONDITION(S) FOR WHICH I SEEK TREATMENT. I UNDERSTAND THAT UNDER NYS LAW, THE PRACTITIONER IS REQUIRED TO ADVISE ME TO CONSULT A PHYSICIAN.**

I further understand that there are some risks associated with acupuncture and that they include possible bleeding, bruising, or irritation at the site of the needle insertion. In addition, I understand that infection can occur and on rare occasions an organ can be punctured by a needle.

In connection with the services I am seeking, I consent to the use of other modalities, such as gua sha, tui na, cupping, and electric stimulation – if the practitioner in his judgment deems it appropriate. I understand that some of these modalities may cause bruising or other temporary markings on the skin.

In the event that herbal therapy is recommended, I understand that I am responsible for the payment of the cost of such herbs.

I understand that the nature of the services provided may be altered in the event of pregnancy as some procedures may be harmful under such circumstances. Accordingly, I agree to advise my practitioner if I am pregnant and understand that this is a continuing obligation.

_____ _____

Patients Name Date

_____

Signature of Patient or Guardian

_____

Practitioners Signature