ANCHORAGE
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Anchorage, Alaska 99501
907.399.5655

pain • injury • rehabilitation • prevention • performance

Shoshana Sadow M.Ac., L.Ac., Dipl.Ac.

Patient Informed Consent for Acupuncture

I, the undersigned, hereby voluntarily authorize Shoshana Sadow, M.Ac., L.Ac., Dipl.Ac. / dba Acupuncture Sports Medicine, a licensed acupuncturist in the State of Alaska to perform the following procedures relating to my health care:

Acupuncture procedures involving insertion of single-use, sterilized acupuncture needles into specific points on the body along with adjunctive therapies described in the Alaska State law outlining the scope of practice for licensed acupuncturists, which includes but is not limited to: acupressure, moxibustion, dermal friction technique, cupping, mechanical, thermal, electrical, and/or electromagnetic treatments, dietary guidelines, therapeutic exercises and lifestyle counseling based on Asian medical theory.

I understand that acupuncture is a safe and effective treatment, but I do recognize the potential risks regarding the procedure of acupuncture and its adjunctive therapies which are listed below, but not limited to: temporary discomfort at the site of the insertion of needles, swelling, bruising, bleeding, tingling, and/or pain. Unusual systematic responses such as nausea, fainting, dizziness or weakness can occur in rare cases. There may be a temporary aggravation of the signs and symptoms that existed prior to the acupuncture treatment.

I understand that if I am pregnant, have a severe bleeding disorder or a pacemaker, I must inform my practitioner prior to treatment.

I understand that the use of Acupuncture and Traditional Chinese Medicine does not exclude the administration of primary medical care by a licensed physician and that I am free to consult a licensed medical doctor regarding any of my health care concerns or changes in my current signs and symptoms.

I understand that the privacy of my Protected Health Information will be maintained and will be kept confidential according to the HIPAA privacy policy regulations. No records will be released without my consent. If it becomes necessary to share my health information, this will be done in accordance with my Notice of Privacy Policies document that has been provided to me by Acupuncture Sports Medicine.

Please read the attached NOTICE OF PRIVACY POLICIES and initial here that you have read it : X
(There is no need to print off the Privacy Policy and bring it to your office visit)

With this understanding, I recognize that no guarantees of success or claims are being made as to the improvement of my presenting condition and that I am giving my consent on a voluntary basis to the above mentioned acupuncture procedures. I hereby release Shoshana Sadow, M.Ac., L.Ac., Dipl. Ac. / dba Acupuncture Sports Medicine from any and all liability which may occur in connection with such procedures and have been informed that the provider is not covered by malpractice insurance.

I understand that I am free to withdraw my consent and discontinue with acupuncture treatment sessions at any time.

Signature of Patient	Date
Signature of Authorized Parent / Guardian	Date