Acupuncture Arts East
62 Brown Street, Ste. 402
Merrimack Medical Center
Haverhill, MA 01830
T: 978.372.4771

PATIENT INFORMATION AND CONSENT TO TREATMENT

Name_____

Address_____

City_____

State_____

Zip_____

Tel # Cell_____

Tel #Home_____

Tel # Work_____

Your Doctor's Name_____

Specialty_____

Tel # _____

Birth Date_____Age_____

Email_____

Occupation_____

Employer_____

In Case of Emergency:
Contact Name_____

Relationship_____

Contact Tel # Cell_____

Contact Tel # Home_____

Contact Tel # Work_____

Referred by: Physician Friend

Website Ad

Present Health Concerns

_____

Consent for Acupuncture Treatment and Care

I, the undersigned, do hereby request and consent to the performance of acupuncture treatments and other Eastern medical procedures. The methods of treatment may include, but are not limited to, acupuncture, far-infrared heat therapy, cupping, electrical stimulation and acupressure.

I have been informed that acupuncture is a safe method of treatment but, occasionally, there may be light bruising or tingling near the needling sites which lasts a few days. There may be some bruising after cupping.

I wish to rely on the acupuncturist to make recommendations during the course of treatment as to what is in my best interest. I understand that I will be informed of any procedures that are recommended before they are performed.

By signing below I agree to the above named procedures. I intend this consent to cover the entire course of treatment for my present condition(s).

Patient's Signature_____ Date_____