

ASBURY ACUPUNCTURE

www.castellinicare.net

Consent Form for Acupuncture

I, the undersigned, hereby authorize Dr. Lesley Castellini, LAc, DC, and Erica Castellini, LCSW, LAc to perform the following procedures:

Acupuncture: The insertion of pre-sterilized, disposable needles through the skin into the underlying tissues at specific points on the surface of the body.

Acupressure, massage, and manual therapy: The use of Traditional Chinese medical massage and therapeutic bodywork.

Infrared heat therapy: Applying heat generated by an infrared lamp over a specific area.

Moxibustion: Heated moxa stick used over specific areas of the body.

Cupping: Glass or plastic cups are placed on the skin with a vacuum created by heat or suction.

Liniments, Essential Oils, Plasters: Herbal or medicinal formulas applied topically to the skin.

Electro acupuncture: Using very small amounts of electricity to stimulate specific acupuncture points.

I recognize the potential benefits and risks of these procedures as described below:

Potential Benefits: Drugless relief of presenting symptoms and improved balance of body energies that may lead to prevention, improvement/prelimination of the presenting problem.

Potential Risks: Discomfort, pain, bruising, blistering, & bleeding at the site of the procedure, temporary discoloration of the skin, possible aggravation of symptoms existing prior to the acupuncture treatment. Burns and/or scarring are potential risks of moxibustion and cupping.

Patients with bleeding disorders, pacemakers, pregnant, have a contagious disease, and who take blood thinners should inform the practitioner prior to receiving treatment.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, and electrical stimulation. Although there are a few possible risks associated with acupuncture and herbal supplements, it remains a relatively safe and effective form of treatment for various disorders. The prognosis of acupuncture care depends on the skill, knowledge, and experience of the practitioner, the patient's condition, the duration and frequency of treatment, and responsiveness of the patient to both treatment and treatment plan. The practitioner will consider other alternatives and options with you as needed for your specific situation.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantee of success or effectiveness of specific treatments has been given to me by Dr. Lesley Castellini, LAc, DC & Erica Castellini, LCSW, LAc regarding cure or improvement of my condition. I hereby release Dr. Lesley Castellini, LAc, DC and Erica Castellini, LCSW, LAc from any and all liability, which may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw this consent and to discontinue participation in these procedures at any time.

Signature of Patient

Date

Signature of Parent or Legal Guardian

Date

Dr. Lesley Castellini, LAc,DC License #25MZ0019400
Erica Castellini, LCSW, LAc License#25MZ00101500