TWIN ACUPUNCTURE
Kerri Kuhlsen, L.Ac., C.SMA
Licensed Acupuncturist, Certified in Sports Medicine Acupuncture®
33 Richmond Hill Road, Staten Island, NY 10314
917.826.0054

Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture by Kerri Kuhlsen, L.Ac. I understand that acupuncturists practicing in the state of New York are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended.

Acupuncture: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibilities to inform Kerri Kuhlsen, L.Ac. if I, or my minor child ever have a change in health.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I also give my permission and consent to be treated by Kerri Kuhlsen, L.Ac.

Signature:_____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____

Guardian/Parent Signature (if under 18) :_____ _____

Address: _____

City: _____ State**:** _____ Zip **Code:** _____ Phone**:** _____