

Informed Consent for Acupuncture Treatment

Patient Information

Name:

Date of Birth:

Address:

Phone:

Description of Procedure

Risks and Benefits

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Patient Acknowledgement

- 1.
- 2.
- 3.

I have read and understand the above information and give my consent to receive acupuncture treatment.

Patient Signature:

Date:

Practitioner Signature:

Date: