

Susan Stewart, RN, AP

ACUPUNCTURE PHYSICIAN
CLASSICAL FIVE ELEMENT ACUPUNCTURE

CLASSICAL MEDICINE
1432 DR MLK STREET NORTH
ST. PETERSBURG, FL 33704

INFORMED CONSENT

I hereby request and consent to acupuncture treatment and/or homeopathic therapy, on me by Susan Stewart, RN, AP. I understand that all known risks and complications will be explained to me. I may request another person of my choice be present in the treatment room during treatment.

I understand that acupuncture is performed by the insertion of special disposable needles through the skin, or in application of heat to the skin, or both at certain points on the body. Acupuncture has the effect to normalize psychological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I understand that results are not guaranteed.

While acupuncture is a safe method of treatment, it can occasionally cause micro-hemorrhages in the tissues. There may be a sensation of warmth, tightness, soreness, or tingling when the needle reaches the acupuncture point. There have been rare instances of fainting, weakness or nausea as a result of needling.

I understand that Susan Stewart, RN, AP is licensed by the State of Florida to practice acupuncture, traditional Chinese herbal supplements, and homeopathy. She is not a medical doctor.

Any procedure used in conjunction with acupuncture will be discussed with me before my treatment begins. I understand that any other procedure suggested is offered in my best interest and based on facts then known.

I understand that payment is due at the time of the appointment. I understand that the office has a \$25.00 returned check fee. I understand that the courtesy of 24-hours notice will be given for any cancellation.

I have read, or have had read to me, the above consent and have also had the opportunity to ask questions and discuss this with Susan Stewart, RN, AP. I agree to acupuncture for treatment of my present condition and any future condition(s) for which I seek treatment. I have the right to refuse or discontinue treatment at any time and understand that this refusal may affect the expected results.

DATE

SIGNATURE OF PATIENT

LEGAL GUARDIAN OR PARENT

GUARDIAN'S RELATIONSHIP
TO PATIENT