Movement Chiropractic
7-3602 Taylor Street East
Saskatoon, SK S7H 5H9

CONSENT FOR ACUPUNCTURE TREATMENT

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, as necessary, including moxibustion, cupping, and/or electroacupuncture by the doctor named below or another duly authorized doctor in the clinic.

I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.

I have been advised that only pre-sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise judgement during the course of treatment which the doctor feels at the time, based upon the facts then know, is in my best interests. I understand that the results are not guaranteed.

I have read the above consent form. I have also had an opportunity to ask questions about its content and by signing below I agree to the above mentioned acupuncture procedures. I intend this consent for to cover the entire course of treatment for my present and future conditions for which I seek treatment.

Female Patients:
I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatments(s) is possible. I hereby state that I am not pregnant, nor is there any possibility that I may be pregnant.

READ BEFORE SIGNING

	X
Patient Name (Printed)	Patient (Parent) Signature
Date	Witness

Russell Matai
Acupuncturist

PATIENT UNDER 18 YEARS OF AGE REQUIRE PARENT OR GUARDIAN'S CONSENT