

**Joseph Teralis Arison, L.Ac.**

9615 Brighton Way, Suite 320

Beverly Hills, CA 90210

(310) 550-0380

**INFORMED CONSENT TO ACUPUNCTURE TREATMENT AND CARE**

Patient's Name \_\_\_\_\_

I hereby request and consent to the performance of procedures which are within the scope of practice of Joseph Teralis Arison, including, but not limited to acupuncture treatments, Visionary Craniosacral Work, and Zero Balancing, on me (or on the patient named above, for whom I am legally responsible) by the acupuncturist named above.

I have had an opportunity to discuss with the acupuncturist named above and/or with other office or clinic personnel the nature and purpose of these listed therapies. I understand that results are not guaranteed.

I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, slight bruising, tingling near the needling sites that last a few days, nausea, and infection. There have been instances reported of fainting, infections, and scarring. There have been instances reported of spontaneous miscarriage and pneumothorax. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal upset or allergic reactions to the herb, I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interest.

I understand that certain techniques used in Visionary Craniosacral Work may involve work within the mouth (with the use of finger cots or gloves) and give permission for this.

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

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
date

\_\_\_\_\_  
Witness to patients signature

\_\_\_\_\_  
date