

SEFTON ACUPUNCTURE CLINIC

CONSENT FORM

Patient name: _____ DOB: _____

Address: _____

Tel: _____ Email: _____

1. Consent to Treatment

I consent to treatment following discussion with my practitioner. Treatment may include acupuncture using sterile, single-use needles, electro-acupuncture, moxibustion, cupping/scraping, massage, heat therapy, and exercise or lifestyle advice, as appropriate to my treatment. I understand that the proposed treatment will be discussed with me and that I can ask questions or withdraw my consent at any time.

I understand that acupuncture may cause temporary discomfort, minor bleeding or bruising, dizziness or fainting, tiredness, or temporary aggravation of symptoms. There is a very small risk of infection and, very rarely, pneumothorax (collapsed lung). I understand that results cannot be guaranteed.

I understand that I should remain still and follow my practitioner's instructions while needles are in place.

2. Heat Lamp / Infrared Therapy

I understand that heat therapy can cause burns or other thermal injury. I have told my practitioner about any relevant medical conditions, including diabetes, reduced sensation/neuropathy, pregnancy, implanted devices, or skin conditions. I will report excessive heat, discomfort or any other concern immediately. Treatment will be monitored and adjusted or stopped as necessary.

3. Medical Information

I confirm that I have provided accurate and relevant information about my health, including medical conditions, recent surgery or procedures and other relevant health information. I will tell my practitioner about any significant change in my health.

Please tick if applicable: ☐ Pregnancy ☐ Pacemaker/implanted device ☐ Bleeding disorder ☐ Blood-thinning medication ☐ Diabetes ☐ Epilepsy ☐ Skin condition/infection ☐ Recent surgery ☐ Previous cancer treatment/surgery

Other relevant information: _____

4. Professional & Medical Care

I understand that acupuncture is complementary healthcare and is not intended to replace appropriate medical diagnosis or treatment. My practitioner will work within their professional scope of practice and the standards of the British Acupuncture Council (BAcC). Where clinically necessary, relevant information may be communicated to my GP or another healthcare professional involved in my care, with my consent where appropriate.

5. Data Protection

My personal and health information will be recorded and stored securely and used for my treatment, clinical records and necessary administration in accordance with UK data protection law. I understand that I have rights regarding my personal data as explained in the Clinic Privacy Notice.

☐ I confirm that I have read the Clinic Privacy Notice.

6. Contact Preferences

☐ I agree to receive clinic updates by email/text. ☐ I do NOT wish to receive clinic updates.

I understand that I can change my preference at any time.

7. Cancellation Policy

I understand that at least 24 hours' notice is required to cancel or rearrange an appointment. Where less than 24 hours' notice is given, or an appointment is missed, the full treatment fee will be charged.

8. Statement of Consent

I confirm that I have read and understood this form, have had the opportunity to ask questions, and understand the nature and potential risks of the treatment described above. I give my informed consent to treatment.

Patient signature: _____ Date: _____

Practitioner signature: _____ Date: _____