Informed Consent for Acupuncture with

Woynarski Management Inc.
Garret Woynarski, RMT

I, the undersigned, do hereby give my voluntary and informed consent for the administration of medical acupuncture and other ancillary techniques as deemed necessary by my treating Therapist.

Acupuncture has been explained to me as a therapeutic treatment performed by the insertion of **single use, sterile, disposable needles**. The needles are inserted through the skin, into the underlying muscles and tissues at specific points in the body for the purpose of alleviating pain, relieving pressure on nerves, improving mobility and re-establishing normal function.

Ancillary techniques of acupuncture may include one or more of the following:

- Electro-acupuncture – where the needles are electrically stimulated at various frequencies to increase the therapeutic benefit
- Dry needling – where muscles are briefly needled by an acupuncture needle held in a holder to release trigger points and spasms
- Cupping – where suction cups are applied to specific points, regions and fascia of the body
- Gua Sha – an instrument assisted technique used for fascia release and circulation increase, which may result in tissue redness or petechiae

I understand that there is the possibility of temporary complications which result from the above listed procedures, which include, but not limited to: minor bleeding, bruising, soreness, nausea, weakness, fatigue, fainting or aggravation of existing symptoms. On the rare occasion, an individual may experience an infection, convulsion or stuck needles.

I further state that the following do not exist in my current state of health and I will notify the Therapist of any health changes or developments:

-Pregnancy - Local Infections -Pacemaker
-Anticoagulants - Bleeding Disorders - Elevated Risk of Infections

I do not expect the Therapist to be able to anticipate and explain all possible risks and complications. I wish to rely on the Therapist to exercise proper judgement during the course of the treatment(s) to make decisions based upon my best interests. I accept the fact that there is no guarantee of treatment effectiveness. I am aware that I may withdraw this consent and discontinue treatment at any time.

I hereby certify that I have I read the above information and have had my questions answered to my satisfaction. By signing below, I agree to the above-mentioned acupuncture procedures.

_____	_____	_____	_____
Date	Patient Name (Print)	Patient Signature	Witness