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**INFORMED CONSENT FOR ACUPUNCTURE/ COLD LASER**

Patient Name: \_\_\_\_\_

Acupuncture/ cold laser is an art of healing which involves the stimulation of specific points on the body to treat disease or relieve pain. The stimulation may be produced by needles, heat, digital pressure, electrical currents and other means. Rarely, patients may experience certain side effects or reactions including fainting, bleeding, pneumothorax, puncture or viscera, broken needles and other hazards associated with the treatment procedure.

Acupuncture/ cold laser has been used in the Orient and Europe as a therapeutic modality, and has been accepted by the National Institutes of Health in the United States for some disorders.

Special consideration is required in people with a history of bleeding disorder or current anticoagulant therapy, implanted pacemaker, prosthetic valve, or pregnancy. I have informed **Samuel D Benjamin MD**, my acupuncturist if any of these conditions exist.

Certain medications or social habits are known to lesson the potential results of acupuncture/ cold laser, these include alcohol, tobacco, steroids, narcotics, and other recreational drugs. I have informed **Samuel D Benjamin MD**, my acupuncturist of any substances and medications which I have used in the past months.

I understand that a series of treatments is usually required to significantly change my condition, and that some people experience no relief.

I the undersigned, do hereby give my voluntary consent for the administration to me of the medical treatment of the method known as acupuncture/ cold laser. This technique is to be applied by, or under the direction and supervision of **Samuel D Benjamin MD**.

I hereby certify that I understand the above authorization and the risk of possible complications. I knowingly waive and decline further information. All questions which I have asked have been answered by **Samuel D Benjamin MD**.

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Signature of Patient or Authorized Agent

Date

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Signature of Witness

Date