ACUPUNCTURE CONSENT OF CARE

I hereby request and consent to the performance of acupuncture (or on the patient named below, for whom I am legally responsible) by Dr. Jacob Walker of Walker Chiropractic & Wellness, P.C..

I have had an opportunity to discuss with Dr. Jacob Walker the nature and purpose of acupuncture. I understand that results are not guaranteed.

I understand and am informed that, acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

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 condition(s) for which I seek treatment.

SIGNATURE DATE

PRINTED NAME