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I, \_\_\_\_\_, do hereby give my voluntary consent for the administration to me of medical treatment by the medical treatment by the method known as acupuncture. The technique is to be applied by, or under the direction and supervision of Sharda Sharma M.D.

Acupuncture has been explained to me as a medical treatment performed by the insertion of special needles (with or without the application of small pulses of electric current to the needles) through the skin into the underlying tissues, for the purpose of the alleviation of pain or treatment of bodily diseases for an undetermined time.

I have been made aware of the possibility of complications which may result from this procedure. These include:

- Infection
- Bruising or bleeding into the tissues
- Fainting (due to the needle reaction)

I accept the fact that there is no guarantee through the use of acupuncture. I am aware that I may withdraw this consent and stop acupuncture treatment at any time.

I understand the above authorization and the risks of possible complications. All questions which I have asked, have been answered by Dr. Sharda Sharma.

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Patient Signature: \_\_\_\_\_