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INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I, hereby request and consent to the performance of acupuncture treatment and other Oriental Medicine Procedures, including various modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by the below named licensed/certified acupuncturist and/or other licensed/certified acupuncturist who now or in the future will treat me while employed by, working or associated with or serving as back-up for the treating acupuncturist named below, including those working at this office/clinic or any other office or clinic.

I understand that methods or treatment may include, but not limited to acupuncture, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese or Western herbal medicine and nutrition counseling.

I have had the opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture treatments and other procedures.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or imbalances of the body. I have been informed acupuncture is the sole method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infection and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

The herbs and nutritional supplements (which are in the form of plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal upset or allergic reactions to the herbs, I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which that acupuncturist feels at the time, based upon the fact then known, and is in my best interest.

I understand the clinical and administrative staff may review my medical records and all reports, but all my records will be kept confidential and will not be released without my written consent.

I have read, or have has 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 conditions and for any future condition(s) for which I seek treatment.

We, the undersigned, do affirm that (the patient) has been advised by, a (licensed/certified acupuncturist), to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

Patient's name _____

Signature _____ Patient's representative _____

Date _____ Relationship of representative _____

Signature of treating acupuncturist _____ Printed name _____