



Informed Consent to Treatment

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of Oriental medicine, 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 acupuncturist and/or other licensed acupuncturist who now, or in the future treat me while employed by, working or associated with, or serving as a back-up for the treating acupuncturist named below, including those working at the clinic or office listed or any other office or clinic, whether signatories to this form or not.

I understand that treatments may include acupuncture, diagnostic techniques (questioning, pulse evaluation, palpation, observation, active and passive range of motion, muscle and orthopedic testing), massage techniques, joint and/or visceral manipulation, heat and/or cold therapy, electrical stimulation (e-stim), instrument assisted soft tissue manipulation (cupping, gua sha), moxibustion, recommendation of herbal and homeopathic preparations for ingestion and/or external application, dietary recommendations, and healthy lifestyle counseling.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I understand and am informed that acupuncture is a safe method of treatment, however, as in allopathic medicine, there are some risks of treatment. I understand that although these risks are unlikely to occur, they are possible. These risks include but are not limited to bleeding, bruising, nerve pain, aggravation of symptoms, appearance of new symptoms, fainting and fatigue. I do not expect the practitioner to be able to anticipate and explain all risks and complications and wish to rely on the practitioner to exercise such judgement to be in my best interest based on the known facts at the time. I understand that I have the choice to accept or reject the proposed diagnostic procedure or treatment, or any part of it, before or during the diagnosis or treatment.

I understand that treatment from the acupuncturist named below does not substitute for appropriate medical evaluation and treatment by a licensed physician. I have been advised to consult with a licensed physician if there is worsening of my ailment/condition, if it does not improve within an estimated timeframe or if a new ailment/condition arises. If I am presently under the care of a physician, I have been advised to continue all treatments and medications as prescribed.

I have read, or have had read to me this informed consent form. 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 that this consent form covers the entire course of treatment for my present and any future conditions for which I seek treatment with this practitioner.

_____/_____/_____
Patient Name (Please print) Patient (or Patient's Representative) Signature Date

_____/_____/_____
Licensed Acupuncturist Name (Please print) Licensed Acupuncturist Signature Date