

INFORMED CONSENT FOR ORIENTAL MEDICAL TREATMENT

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

There are some risks to treatment, including but not limited to some bruising of the skin and or/ slight bleeding. If moxibustion or heat therapies are used there is a risk of burn and/or scarring. The risk of infection is small when all needles are sterile. Needles are considered sterile when they are either disposable or are autoclaved according to applicable state legal requirement.

I have had an opportunity to discuss with the acupuncturist named below the nature and purpose of Oriental medicine. I understand that results are not guaranteed.

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

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 the acupuncturist is not providing Western (allopathic) medical care, and that I should look to my Western primary care practitioner (*i.e.* MD) for those services and for routine check-ups.

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.

PATIENT

SIGNATURE:

(Or Patient Representative)

X _____

(Indicate relationship if signing for patient)

DATE: _____

PLEASE DO NOT WRITE BELOW THIS LINE, UNTIL DISCUSSING IT WITH YOUR ACUPUNCTURIST

Estimated Number Of Times The Patient May Need To Return For Treatment:

5-10 10-20 20-50 More Than 50 Other _____

Estimated Frequency of Treatment:

Once Each Week Twice Each Month Once Each Month Other _____

Possible outcome of treatment:

Relief from Discomfort Stabilization of Condition Reversal of Condition
 Other _____

The Acupuncturist has discussed the above information with me; she has described all proposed procedures to me, and I understand this information.

Patient's Signature _____

Date: _____

I have discussed the above information with the patient, including the risks, benefits, and alternatives to the proposed treatment.

ACUPUNCTURIST'S SIGNATURE: _____

Date: _____