



## INFORMED CONSENT TO ACUPUNCTURE/ORIENTAL MEDICINE TREATMENT

I hereby request and consent to Acupuncture/Oriental Medicine treatment(s) and other clinical procedure(s) provided to me (or to the patient listed below, for whom I am legally responsible) by the below named Licensed Acupuncturist and/or any other Licensed Acupuncturist who now or in the future may 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 clinic or any other clinic.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, application of heat, Tui-Na, Chinese or Western herbal supplements, and informal nutritional and lifestyle counseling.

I have been informed that Acupuncture/Oriental Medicine treatments are generally safe, but some of the following side effects may occur:

- There may occasionally be bruising, numbness or tingling sensations on or near the needling sites that may last a few days.
- There have been very rare instances reported of fainting, infections, and scarring.
- There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax.
- Burns and/or scarring can be a potential risk of moxibustion.
- There may be bruising after cupping.

The herbal and nutritional supplements (which are from plant, animal, or mineral sources) that may be recommended are generally considered safe in the practice of Oriental Medicine, although some of them may have toxic effects in large doses. I have been informed that some of the possible side effects of taking herbal medicines may include nausea, vomiting, diarrhea, gas, stomachache, rashes/hives, and tingling sensation of the tongue. If I experience any of these reactions, I will promptly inform the treating Acupuncturist.

I understand that some herbal and nutritional supplements may be inappropriate during pregnancy. Thus, I will notify the treating Acupuncturist if I am or may be pregnant. I acknowledge that some of the herbal and nutritional supplements need to be prepared and consumed according to the instructions provided by the treating Acupuncturist.

I do not expect the treating Acupuncturist to be able to anticipate and explain to me all the potential risks and possible complications of the treatment(s) I receive, but I wish to rely on the clinic staff to exercise prudent judgment during the course of treatment which the treating Acupuncturist feels at that time, based on the facts then known, to be in my best interest.

I understand that the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released to any party without my written consent. By voluntarily signing this Informed Consent Form, I acknowledge that I have read, or have had read to me, this informed consent to treatment. I agree to the aforementioned procedures as deemed necessary by the treating Acupuncturist.

I understand that this Informed Consent agreement will cover the entire course of treatment for my present condition as well as for any future condition(s) for which I seek treatment.

\_\_\_\_\_  
Signature of Patient (or Representative)

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

\_\_\_\_\_  
Print Name of Patient (or Representative)

\_\_\_\_\_  
Relation to Patient (if applicable)

\_\_\_\_\_  
Patient's Name (if different from the above signed)