

INFORMED CONSENT TO ACUPUNCTURE AND ORIENTAL MEDICINE TREATMENT AND CARE

Name and Address of Clinic/Office:

Print Name(s) of Doctor(s) Treating this Patient:

Print Patient's Name

I hereby request and consent to the performance of procedures which are within the scope of practice of acupuncture and oriental medicine including, but not limited to, acupuncture, moxabustion, cupping, electro acupuncture, herbology, various modes of physiotherapy, on me (or on the patient named above, for whom I am legally responsible) by the acupuncturists named above and/or other licensed acupuncturist who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named above, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the acupuncturist named above and/or with other office or clinic personnel the nature and purpose of acupuncture, moxabustion, cupping, electro-acupuncture, herbology, physiotherapy and other procedures. I understand that results are not guaranteed.

I understand and am informed that there are some risks to acupuncture and oriental medicine treatment, including, but not limited to, slight bruising, tingling near the needling sites that last a few days, nausea, infection, and blisters. There have been instances reported of fainting, infections and scarring. There have been instances reported of spontaneous miscarriage and pneumothorax. I understand that some herbs may be inappropriate during pregnancy. If I suspect I am pregnant, I will immediately inform the acupuncturist. If I experience any gastro-intestinal 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 judgement during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interests.

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.

Signature of Patient or Patient's Representative

Print Name of Patient's Representative

Witness to Patient's Signature

Date

Relationship or Authority of Representative

Translated by

Date