

TRADITIONAL CHINESE MEDICINE INFORMED CONSENT TO TREAT & FINANCIAL POLICY

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I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of Chinese/Oriental medicine on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named above and/or other licensed acupuncturists who now or in the future treats 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 understand that methods of treatment within the scope of Chinese/Oriental medicine may include, but are not limited to, acupuncture, acupressure, moxibustion (direct or indirect application of heat to acupuncture points or needles), cupping (cups made of glass or other materials placed on the skin with a vacuum created by heat or other device), electrical stimulation (use of electrical device to produce electrical stimulation on the acupuncture needles), Tui-Na (Chinese massage), gua sha (Chinese dermal friction technique), bleeding, bleeding cupping, breathing, relaxation, and East Asian exercise techniques, Qi gong, Chinese herbal medicine, and nutritional counseling based on traditional Chinese medical theory. The later may include the sale of herbs, vitamins, minerals, and dietary and nutritional supplements. I understand that the herbs may need to be prepared and the teas consumed (or applied on the skin) according to the instructions provided orally and in writing. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption or application of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, dizziness or fainting, and needle sickness. Occasionally, needles can break. Bruising is a common side effect of cupping. Burning and/or scarring are potential risks of moxibustion and cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment other side effect and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I understand that some herbs may interact with prescription, over-the-counter medication, or supplements, and as such, I will notify the acupuncturist named below if I am taking any medication or supplements concurrently with Chinese herbs. I understand that some herbs may be inappropriate during pregnancy. **I will notify an acupuncturist member who is caring for me if I am or become pregnant. Patients with severe bleeding disorders, pace makers, diabetes, contagious diseases or lymphedema should inform practitioners prior to any treatment.**

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks best at the time based upon the facts then known. I understand that results are not guaranteed. 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 understand that the acupuncturist may review my patient records and lab reports.

I understand acupuncture treatments are my financial responsibility and I agree to pay for these services at the time of treatment unless other arrangements have been made. **I will provide my acupuncturist with at least 24 hours notice if I need to cancel or reschedule an appointment and I understand that I will be charged \$50.00 for any appointment broken with less than 24 hours notice.**

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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's Printed Name _____

Signature of Patient or Representative _____ Date _____