Informed Consent to Treatment

I consent to acupuncture treatments and other procedures associated with Oriental Medicine. I have discussed the nature and purpose of my treatment. I understand that methods of treatment may include, but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, Shiatsu or Tui-Na (massage modalities), herbal medicine, linaments and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but may have side effects. These include bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although this practitioner uses disposable sterile needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

The herbs and nutritional supplements (from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. Some herbs may smell or taste unpleasant.

I will notify the practitioner if I am or become pregnant.

I do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on the acupuncturist to exercise judgment during the course of treatment which they think, based upon the facts then known, is in my best interests.

I understand the practitioner may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below I show that I have read this 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 any future conditions for which I seek treatment.

(If represented by another)

Print Name	(Print Name of Representative)
x Signature	(Signature of Representative)
Date	