I. PATIENT ADVISORY TO CONSULT A PHYSICIAN

Asian Medicine, including acupuncture, has a great deal to offer as a health care system. However, it is intended to be integrated with the resources that are available through the Western medical system. Therefore, we recommend that you consult a physician regarding any condition for which you are seeking treatment as well as informing them of the care you are receiving here.

I acknowledge I have read and understand this advisement to consult a physician.

Patient signature [if patient representative, indicate relationship]	**Date**
X	

II. ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture and other procedures within the scope of practice of acupuncture on me [or the patient named below for whom I am legally responsible] by the acupuncturist named above.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, bleeding, cupping, electrical stimulation, Tui- Na [Chinese Massage], Chinese herbal medicine, and lifestyle and nutritional counseling.

I have been informed that acupuncture is considered to be a safe method of treatment, but that it may have some side effects, including bruising, dizziness, fainting, slight bleeding, and numbness or tingling near the needling sites that may lasts for a few days. Burns, and/ or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual and exceedingly rare risks of acupuncture may include spontaneous miscarriage, nerve damage and organ puncture. A licensed acupuncturist is trained to avoid such unusual side effects, including Infection since the practitioner uses sterile disposable needles and adheres to universal precautions.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I will notify the clinical staff member who is caring for me if I: suspect I am, or become, pregnant; have a bleeding disorder, pacemaker, local infections, and/or I am taking anticoagulants.

I do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the practitioner to exercise judgment during the course of treatment which the practitioner thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand that all my records will be kept confidential and will not be released outside of the clinical and administrative staff within this center without my written consent.

I understand the payment for services is due at the end of each treatment session. Further, any cancellations made with less than 24 hours notice, or a "no-show" will incur the full charge for the appointment.

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 Name [Print]

Patient Signature [if patient representative, indicate relationship]	**Date**
X	