



Informed Consent

I, the undersigned, hereby give consent for the administration of treatment by the method of acupuncture and Oriental medicine that is relevant to my diagnosis and treatment, including but not limited to the following procedures.

I understand the following: Acupuncture is performed by the insertion of needles, with or without the addition of an electric current, through the skin or the application of heat to the skin, or both, at certain points on the body in an attempt to improve body function and/or relieve pain. A massage-like technique called “gua sha” or cupping may be used. This treatment leaves redness on the skin for 1-5 days. Slight bruising or tenderness may persist after treatment. Bloodletting, alone or in conjunction with cupping, may be used to improve circulation in meridians. Chinese herbal medicine in various forms may be administered orally and/or topically, and some patients may experience side effects from their particular prescription.

I have been made aware that certain side effects may result. These may include, but are not limited to, some local bruising, bleeding, fainting, temporary pain or discomfort and the possible aggravation of symptoms existing prior to the above stated treatments.

I understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment.

I understand that the results obtained from this treatment may be published, but that my identity will not be revealed.

I understand that from time to time a student of acupuncture may be present at the time of my treatment.

I understand that none of the foregoing provisions shall prevent administration to me of more conventional medical therapy by a licensed physician when in his or her own discretion such therapy is deemed appropriate.

I hereby certify that I have read the above and that I understand the provisions described therein.

Patient Signature _____ Date _____