Bay Area Oriental Family Practice, P.A.

INFORMED CONSENT. PLEASE READ AND SIGN.

I herby request and consent to the performance of acupuncture treatments and other procedures with the scope of the practice of acupuncture on me (or the patient named below, for whom I am legally responsible) by the acupuncturist named below 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 below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Oriental massage), Oriental herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is generally safe method of treatment, but that it may have some reactions including bruising, numbness or tingling near the needling sites that may last a few days (generally no harm to the body), and dizziness or fainting (normally caused by low blood sugar, or nervous or standing up too fast). I will make sure I am not hungry when get acupuncture. Bruising is a common sign of cupping. Burns and/or scarring are potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects 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 Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify the clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.
At the time of treatment, payment is due. Our office policy on insufficient funds is $35.00.

PATIENT SIGNATURE_____**DATE**:_____

DRIVER'S LISCENSE NUMBER_____

PLEASE SUPPLY US WITH PHOTO IDENTIFICATION. THANK YOU FOR YOUR COOPERATION.