INFORMED CONSENT FOR EAST ASIAN MEDICINE TREATMENT AND FINANCIAL POLICY

Federal Way Acupuncture Center, Licensed in WA State

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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 East Asian 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 treat 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 below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment within the scope of East Asian medicine may include, but are not limited to, acupuncture, including the use of acupuncture needles or lancets to directly or indirectly stimulate acupuncture points and meridian, use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians, moxibustion, acupressure, cupping; dermal friction technique; infra-red; sonopuncture; laserpuncture; point injection therapy (aquapuncture); dietary advice and health education based on East Asian theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements; breathing, relaxation, and East Asian exercise techniques; qi gong; East Asian massage and Tui na, which is a method of East Asian bodywork, characterized by the kneading, pressing, rolling, shaking, and stretching the body and does not include spinal manipulations; and superficial heat and cold therapies. 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 needling sickness. Rarely, 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 effects 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 East Asian 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 above 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 must 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 based on what the acupuncturist deems 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 am responsible for payment. In the event that my insurance coverage expires or denies payment, for any reason, I understand that I am personally responsible for all fees incurred. I am responsible for payments toward deductible, and for copays or co-insurance. I understand that I am responsible for letting my practitioner know if pre-authorization for acupuncture treatment is required per my insurance plan. If I do not let my practitioner know, I am responsible for any claims denied because a pre-authorization request was not submitted.

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the practitioner's day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a $30 cancellation fee.

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.

_____ _____

Signature of Patient or Legal Representative Date

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Printed Name