I. PATIENT ADVISORY TO CONSULT A PHYSICIAN

Confluence Healing is committed to your health and well being. While acupuncture and traditional Oriental medicine have a great deal to offer as a health care system, it cannot totally replace the resources available through medical doctors. Therefore, we recommend that you consult a physician regarding any condition for which you are seeking treatment. Additionally, after a certain length of time, you may be asked to obtain a note from your doctor in order to continue acupuncture and/or herbal therapy when the ongoing treatment pertains to a medical condition that has not yet resolved and/or has not been assessed by an M.D.

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

Patient Initials X _____ [if patient representative, indicate relationship] _____

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 below and /or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as a 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 [Chinese Massage], Chinese herbal medicine, and lifestyle 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. These herbs may have an unpleasant taste or smell. 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 a generally safe method of treatment, but that it may have some side effects, including bruising, dizziness, fainting, and numbness or tingling near the needling sites that may last 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 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 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 Chinese 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. **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.

I understand that the clinical and administrative staff may review my patient records and lab reports, but that 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, 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

Signed L.Ac._____ Date _____