INFORMED CONSENT
FOR ACUPUNCTURE & ORIENTAL MEDICINE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Santee Acupuncture.

I understand that the methods of treatment may include, but are not limited to, acupuncture, acupressure, moxibustion, cupping, electrical stimulation, Tui-na and Chi Nei Tsang (Chinese medical massage), Chinese herbal medicine, lifestyle recommendations, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, and that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not move while the needles are being inserted, retained, or removed. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, is in my best interest.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I understand that the results are not guaranteed. I understand that the office medical and administrative staff may review my medical records and lab reports, and 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, this consent to treatment, have been told about the risks and benefits of acupuncture, and have had an opportunity to ask questions.

Patient Name _____

Signature_____Date_____

To be completed by the patient's representative if patient is a minor or is physically or legally incapacitated:
Print name of representative_____

Relationship or Authority of Patient_____