

INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other East Asian procedures, within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Wellness Garden and its licensed acupuncturists who now or in the future may treat me while employed by, working for or associated with or serving as a back-up for the practitioners of Wellness Garden, including those working at this office/clinic/site or any other office, clinic, or site of Wellness Garden.

I understand that methods of treatment may include, but are not limited to, acupuncture, acupressure, moxibustion, cupping, electric stimulation, Tui-Na (Chinese Massage), Chinese 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 have 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 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, and dizziness or fainting. 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 and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect 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 a clinical staff member who is caring for me if I am pregnant, become pregnant, or am attempting to become pregnant.

I do not expect that clinic staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff of Wellness Garden to exercise judgment during the course of treatment which the clinical staff thinks at the time, based on the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but 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, understand 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 further condition(s) for which I seek treatment.

I hereby release Wellness Garden, its staff, and contractors from any and all liability that may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care.

Patient Signature

Legal Representative (if signing for patient)

Printed Name of Patient

Relationship to Patient (if signing for patient)

Date: _____