ATP Acupuncture & Chinese Medicine

Informed Consent to Treatment

I consent to acupuncture treatment and other procedures associated with Traditional Chinese Medicine by the member of the ATP Acupuncture & Chinese Medicne's Medical Staff. I have discussed the nature and purpose of my treatment with the member of the Clinical Staff named below.

I understand that methods of treatment may include, but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese or Western herbal medicine, and nutritional counseling.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunction of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising, tingling or numbness the near needling sites that may last a few days. There have been very rare instances reported of fainting, infecting and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy.

I understand that the herbs need to be prepared and the tea 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 Clinic Medical Staff of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I will notify the Clinic Medical Staff member who is caring for me if I am or become pregnant.

I do not expect the Clinic Medical Staff to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on the Clinic Medical Staff to exercise judgment during the course of treatment that the Clinic Medical Staff thinks at the time, based upon the facts then known, is in my best interest.

I understand that the Clinical Medical and administrative staff may review my medical 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 had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. No guarantee has been made. 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.

To be completed by patient (or by patient's representative if the patient is a minor or is physically or legally incapacitated)

Print name of patient

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Signature of Patient (or Representative)

Date signed -----/ ----/ ------

To be completed by the member of the Clinical Medical Staff providing information and obtaining consent.

Print name of Clinic Medical Staff

x---
Signature of Clinical Staff