INFORMED CONSENT TO ACUPUNCTURE & ORIENTAL MEDICINE TREATMENT AND CARE

I ___________________________ hereby request and consent to the performance of procedures which are within the scope of practice of acupuncture and oriental medicine including, but not limited to, acupuncture, moxibustion, cupping, electro acupuncture, herbology, various modes of physiotherapy by the acupuncturist at Knoll Acupuncture.

I have had an opportunity to discuss with the acupuncturist and/or with other office or clinic personnel the nature and purpose of acupuncture, moxibustion, cupping, electro-acupuncture, herbology, physiotherapy and other procedures. I understand that results are not guaranteed.

I understand and am informed that there are some risks to acupuncture and oriental medicine treatment, including, but limited to, slight burning, tingling near the needling sites that last a few days, nausea, infection and blisters. There have been instances of fainting, infection and scarring. There have been instances reported of spontaneous miscarriage and pneumothorax. I understand that some herbs may be inappropriate during pregnancy. If I suspect I am pregnant, I will immediately inform the acupuncturist. If I experience any gastro-intestinal upset or allergic reactions to the herbs, I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, and is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for the present condition and for any future condition(s) for which I seek treatment.

______________________________	______________________________
Signature of Patient or Representative	Print Name of Patient's Representative
______________________________	______________________________
Witness to Patient's Signature	Relationship to Representative
______________________________	______________________________
Translated By	Date