Informed Consent

ACUPUNCTURE & ORIENTAL MEDICINE

I hereby request and consent to the performance of acupuncture treatments and other complementary medicine procedures, including various modes of physiotherapy, on me (or on 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 back-up for the Acupuncturist named below, including those working at this office or clinic.

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.

I have had the opportunity to discuss with the Acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture treatments and other procedures.

Acupuncture attempts to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that lasts a few days. There have been very rare instances reported of fainting, infection, 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 the practice of Chinese medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal 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. 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, is in my best interests.

I understand that the clinical 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.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content.

By signing below, I agree to the above-named procedures. 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 THE PATIENT

PATIENT NAME (PLEASE PRINT) _____ PATIENT SIGNATURE _____ DATE SIGNED _____

TO BE COMPLETED BY THE PATIENT'S REPRESENTATIVE if the patient is a minor or is physically or legally incapacitated

NAME OF PATIENT (PLEASE PRINT) _____ REPRESENTATIVE (PLEASE PRINT) _____ RELATIONSHIP / AUTHORITY _____

REPRESENTATIVE SIGNATURE _____ DATE SIGNED _____

Treating Acupuncturist: Menakshi (Mena) C. Rajan, L.Ac., MSTOM, Dipl. O.M.