Abundant Heaven Traditional Chinese Medicine
www.abundant-heaven.com

Informed Consent To Treat

I hereby request and consent to the performance of acupuncture, tuina (Chinese Medical Massage), and other procedures, as deemed necessary for my treatment that are within the scope of practice of my practitioner's licensure, on me (or on the patient named below for whom I am legally responsible). These services will be provided by the acupuncturist named below and/or other licensed acupuncturists who now or in the future may treat me while being employed by, working or associated with the acupuncturist named below, whether their names appear on this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, tuina (Chinese Medical Massage), Chinese herbal medicine, nutritional counseling, therapeutic exercise instruction, and craniosacral therapy. I understand that some of the herbs require preparation and that I must follow the instructions provided to me orally or in writing regarding their preparation and consumption. 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 herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that, like all medical procedures, one may experience side effects including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although our clinic uses sterile, FDA proved, single-use, disposable needles and maintains a clean and safe environment. Bruising is a common side effect of cupping. Burns and/or scarring are a potential risk of moxibustion and cupping. Tuina (Chinese Medical Massage) can produce soreness and may temporarily increase pain and sensitivity for a immediately or for few days after treatment. There is the possibility that craniosacral therapy may aggravate existing conditions and their associated symptoms, before resolution occurs, which may include a feeling of unsettled emotions, physical sensations, or re-experiencing of past trauma. This has been explained to me as being part of the healing process.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which come from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, through supervised administration of a licensed practitioner, although some herbs may be toxic in large doses. Some possible side effects of taking herbs are nausea, gas, stomach ache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

I understand that some herbs may be inappropriate during pregnancy or when taken with certain medications. It is my responsibility to inform the clinic staff member who is caring for me if I am pregnant or if I intend to become pregnant. It is also my responsibility to provide the clinic staff member whose care I am under, complete and up-to-date information regarding any and all prescribed medications and supplements that I am currently taking.

I understand that 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 this document read to me, regarding content to treatment. I have been informed of the risks and benefits of acupuncture and other procedures and have had the opportunity to ask questions. I intend for 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.

Acupuncturist Name: _____ (Date)

Patient Signature: X _____

(Or Patient Representative) (Indicate relationship if signing for patient)