

INFORMED CONSENT FOR ORIENTAL MEDICAL TREATMENT

TCM Acupuncture Clinic

Florida Institute of Acupuncture and Integrative Medicine

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of Oriental medicine on me (or on the patient named below, for whom I am legally responsible) by the practitioner of Oriental medicine named below and/or other practitioners of Oriental medicine who now or in the future treat me while employed by, working or associated with or serving as back-up for the practitioner named below, including those working at the clinic or office listed below, whether signatories to this form or not.

I understand that I will undergo treatment of Acupuncture and other therapeutic methods within the scope of the practice of Oriental medicine. I am aware that Acupuncture means the insertion of disposable fine form needles into the body. I understand that there are some risks to treatment, including but not limited to some bruising of the skin and or/ slight bleeding. If moxibustion or heat therapies are used there is a risk of burn and/or scarring. The risk of infection is small when all needles are sterile. Needles are considered sterile when they are either disposable or are autoclaved according to applicable state legal requirement.

I do not expect the practitioner to be able to anticipate and explain all risks and complications. I wish to rely on the practitioner to exercise judgment which the practitioner feels at the time is in my best interest, based upon the facts then known, during the course of the procedure. I understand that I have the choice to accept or reject the proposed diagnostic procedure or treatment, or any part of it, before or during the diagnosis or treatment.

I understand that **the practitioner is not providing Western (allopathic) medical care**, and that I should look to my Western primary care practitioner (i.e. MD) for those services and for routine check-ups.

I have read, or have had read to me, the above consent. I have had an opportunity to discuss with the practitioner named below the nature and purpose of Oriental medicine. I understand that results are not guaranteed. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intent 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.

PRACTITIONER'S SIGNATURE: _____ **Date:** _____

PATIENT SIGNATURE: (Or Patient Representative)	X
DATE:	(Indicate relationship if signing for patient)