East Wind Acupuncture and Tuina Healing Center

Informed Consent

I hereby request and consent to the treatment of acupuncture and other modalities within the scope of the practice of Traditional Chinese Medicine for me (or 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 the clinic or office listed below.

I understand that the acupuncturist obtained and passed the educational requirements, the National Exams and is licensed to practice in Minnesota. I understand that methods of treatment may include, but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese medical Massage), Oriental herbal medicine, dietary therapy and exercise recommendations.

I have been informed that acupuncture is generally a safe method of treatment. Possible side effects which may occur include: bruising, pain, numbness or tingling near the insertion sites that may last a few days, dizziness or fainting. Bruising is a common side effect of cupping and gua sha. Burns and/or scarring are a potential risk of moxibustion and cupping. Unusual risks of acupuncture include spontaneous miscarriage, broken needles, needle sickness, nerve damage and organ puncture, including lung puncture (pnuemothorax). Infection is a possible risk; however, the clinic uses sterile disposable needles and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I understand that the herbal treatment may need to be prepared and the teas 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 clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs. The herbs and nutritional supplements (which are derived from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic if consumed in large doses. Some possible side effects of taking herbs include; nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I experience any of these symptoms or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on the clinical staff to exercise judgment during the course of treatment based upon the facts then known to be in my best interest. I understand that results are not guaranteed.

I understand that the clinical and administrative staff may review patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that acupuncturists do not perform a Western (biomedical) diagnosis and that it is my responsibility to seek such diagnosis elsewhere if I have not already done so. I understand that I may be referred to my primary care physician when the acupuncturists believe my condition to be outside the scope of their practice.

By voluntarily signing below I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment within the scope of practice of Traditional Chinese Medicine.

I understand and agree that I am ultimately responsible for the balance on my account and that payment in full is due at the time services are received. I understand that a minimum 24-hour notice of cancellation is required in the event that I may need to cancel a scheduled appointment. Failure to do so will result in my being responsible for the full fee of the missed scheduled appointment time. All unpaid fees must be paid in full prior to receiving a subsequent treatment.

I have/have not (circle one) been examined by a licensed physician or other licensed health care provider with regard to my illness or injury. If yes, I have informed the clinical staff of the diagnosis.

I have a pace maker and/or bleeding disorder (circle the ones that apply).

By signing below I acknowledge that all information provided is accurate to the best of my knowledge.

Patient signature:_____ Date:_____

Legal guardian:_____ Date:_____

Office Representative:_____ Date:_____