

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. I am seeking consultation with this office to assist me in understanding and developing methods to improve my health.

I understand that in the state of North Carolina, practitioners of Chinese medicine are not primary care physicians. Thus, it is expected that patients are under the care of a primary care or medical specialist. I understand that in this context, Chinese medicine is not meant to be nor legally able to present as a substitute for diagnosis or treatment, nor considered replacement for medical care or diagnostic testing from western medical physicians.

I hereby request and consent to the performance of acupuncture treatment, bodywork, herbal formulation and other procedures within the scope of practice of Chinese medicine in the state of North Carolina on me (or individual for whom I am legally responsible) by licensed Chinese medicine practitioners at the Alternative Clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, bodywork, and herbal medicine prescription. I understand that herbs are prescribed by a licensed and trained herbalist, and are expected to be prepared and consumed according to the specific instructions and dose provided by practitioner.

I appreciate that it is not possible to consider every possible complication to care. I understand that this document must legally describe the major risks of treatment, and I understand that other side effects and risks may occur.

I have been informed that acupuncture is a generally safe method of treatment, but as with all types of health care interventions, there are some risks including but not limited to: bruising; numbness or tingling, dizziness or fainting, burns, bruising and/or scarring. Unusual risks of acupuncture include nerve damage, organ puncture and infection.

I also understand as a 501c3 teaching clinic, chief practitioners will have assistants present for the duration of intake and treatment. My case will be discussed for educational purposes in order to fulfill the Alternative Clinic's not for profit mission of improving medical care in our field. I understand that if I seek a more private treatment experience, I may schedule with clinic practitioners who do not have observers, and / or turn to the many other acupuncture practitioners in Asheville.

I understand that it is my responsibility to fully inform, and continue to inform, this office of any medical history, family history, medical diagnoses, medication changes, and/or supplements taken currently. I understand that staff and interns may review and discuss my case, however my name, date of birth and personal details will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than Chinese medical therapies. I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm that I have read, or have had read to me, the 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 for my present condition and for any future condition(s) for which I seek treatment.

Signature _____