

INFORMED CONSENT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture 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 the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Oriental massage), Oriental herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be 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.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect and risks may occur. 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 Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

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

I understand 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 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 for my present condition and for any future condition(s) for which I seek treatment.

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

OFFICE SIGNATURE	Date
-------------------------	------

PLEASE SIGN REVERSE SIDE ALSO

**Patient's Consent For The Purposes of Treatment, Payment
And HealthCare Operations**

I _____ give consent to Raleigh Acupuncture Clinic

To use and disclosure of my Individual Identifiable Health Information or Protected Health Information for the specific purposes:

1. Providing treatment to me.
2. Relating to the payment of the services this office has rendered to me.
3. The general administrative operations this practice provides to me.

The purpose of this consent:

Protected Health Information is any information that includes;

1. Demographic Information
2. Information gathered by this practice as it relates to my past, present and future.
3. Information gathered by this office for past, present or future payments for providing the healthcare services.
4. Healthcare operations purposes will include quality assessment activities, credentialing, business management and other general operations procedures or activities.

I understand I have the right to request or put restrictions on the use and disclosure of my Protected Health Information for the purposes of treatment, payment of healthcare operations of the Acupuncture practice, but the practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the practice.

I understand I have the right to read and discuss the Notice of Privacy Policies and Procedures form of this acupuncture practice before I sign this consent form regarding the use and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time except to the extent that the acupuncturist or the practice has acted in reliance on this consent.

Signature of Patient or Personal Representative date _____

Description of Personal Representative's Authority _____ date _____