

# TEXAS ACUPUNCTURE CLINIC

## Informed Consent to Chinese Medical Health Care

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by the licensed acupuncturists on staff at the Texas Acupuncture Clinic (TAC) now or in the future treat me while employed by, working or associated with or serving as back-up for TAC, including those working at this clinic: acupuncture and other Chinese Medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle, etc.; modes of manual or physical therapy such as Asian body work, acupressure, insertion and manipulation of acupuncture needles, administration of thermal or electrical treatments, moxibustion; energy flow exercise; the prescription of herbal as well as dietary supplements; dietary recommendation; exercise advice and healthy lifestyle counseling.

I have had an opportunity to discuss with my professional practitioner, and/or with other clinic personnel the nature and purpose of acupuncture and Chinese Medicine procedures. Although I am aware that acupuncture and the other procedures used in Chinese Medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of allopathic medicine, in the practice of Chinese Medicine there are some risks of treatment. I understand that although these risks are unlikely to occur, they are possible, particularly when face rejuvenation acupuncture is given. I understand that these risks include, but are not limited to: bleeding, bruising, puncture of organs, pain or other strong sensation at the location of where a needle is inserted or radiating from that location, nerve pain, burns, blisters, aggravation of current symptoms, appearance of new symptoms, general aches, fatigue, dark red or purple marks from cupping, skin itching, redness, discomforts from taking herbs, sprains, strains, dislocation, miscarriage, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioner, to exercise such judgment, during the course of my treatment, as the practitioner feels at the time, based on the facts known, to be in my interest. I authorize the staff to perform any necessary services needed during diagnosis and treatment.

I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. 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 at the Texas Acupuncture Clinic.

\_\_\_\_\_  
Patient's name (please print)

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Date signed

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Print name of patient's representative (if applicable)

\_\_\_\_\_  
Relationship or authority of patient's representative

\_\_\_\_\_  
Signature of patient's representative (if applicable)

\_\_\_\_\_  
Date Signed