Consent to Treat, Advisement to Consult Medical Doctor, Right to Privacy

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or the patient named below, for whom I am legally responsible) by the acupuncturist signed 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 signed below, including those working at this clinic or office 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/or in writing. The herbs may be unpleasant in 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 needle site 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 potential risks of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects may occur. The herbs and nutritional supplements (which are from animal, plant, 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, based on the facts then known, the clinical staff thinks at the time is in my best interests. I understand that results are not guaranteed.

I understand and have been informed that licensed acupuncturists are not authorized as primary caregivers under New York state law, and it has been recommended that I consult a Western medical doctor.

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

I understand that any cancellation or rescheduling of an appointment with less that 24 hours notice may be subject to a cancellation fee. Said fee is 75% of the regular treatment cost.

By voluntarily signing below, I show that I have read, or have had read to me, the above form, have been told about the risks and benefits of acupuncture and other procedures, and have had the opportunity to ask questions. I intend this form to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment.

PATIENT NAME _____ DATE _____

PATIENT SIGNATURE _____
(or Patient Representative; indicate relationship if signing for patient)

SIGNATURE OF L.AC. _____
(Dr. Juan Torres, DACM, L.Ac.)