INFORMED CONSENT TO ACUPUNCTURE TREATMENT AND CARE

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 one of the patients named below, for whom I am legally responsible) by the acupuncturist 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, including those working at the clinic or office of Golden Root Acupuncture or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the acupuncturist and/or with other office or clinic personnel the nature and purpose of acupuncture. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine in the practice of acupuncture, there are some risks to treatment, including, but not limited to, nausea, a punctured lung, and infection. I understand and am informed that, the scope of practice of acupuncture includes the use of moxibustion and cupping, and some risks to treatment while using said modalities, include, but are not limited to, burns, blisters, and infection. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. 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.

To be completed by patient:

Print Patient's Name

Signature of Patient

Date Signed

To be completed by patient's representative, if necessary, e.g., if patient is a minor or physically or legally incapacitated:

Print Name of Patient

Print Name of Patient's Representative

Signature of Patient's Representative

As: Relationship or authority of Patient's Representative

Date Signed