INFORMED CONSENT TO ACUPUNCTURE AND ORIENTAL MEDICINE TREATMENT AND CARE

Clinic Office:
Laurel Acupuncture
239 Laurel St. Suite 102
San Diego, CA 92101

Practitioner:
Jim Chialtas, L.Ac.
Lic. # AC 8918

Patient's Name: ____

I hereby request and consent to the performance of procedures which are within the scope of practice of acupuncture and oriental medicine including, but not limited to, acupuncture, moxabustion, cupping, electro acupuncture, herbology, various modes of physiotherapy, on me (or on the patient named above, for whom I am legally responsible) by the acupuncturist named above.

I have had an opportunity to discuss with the acupuncturist named above and/or with the other office or clinic personnel the nature and the purpose of acupuncture, moxabustion, cupping, electro acupuncture, herbology, physiotherapy, and other procedures. I understand that results are not guaranteed.

I understand and am informed that there are some risks to acupuncture and oriental medicine treatment, including, but not limited to, slight brusing, tingling near the needling sites that may last a few days, nausea, infection, and blisters. There have been instances reported of fainting, infections, and scarring. There have been instances reported of spontaneous miscarriage and pneumothorax. I understand that some herbs may be inappropriate during pregnancy. If I suspect I am pregnant, I will immediately inform the acupuncturist. If I experience any gastro-intestinal upset or allergic reactions to the herbs, I will inform the acupuncturist.

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.

______________________________________ ______________________________

Signature of Patient or Patient's Representative — Date

Print Name of Patient's Representative

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Relationship or Authority of Representative