CONSENT FORM FOR TREATMENT

I consent to acupuncture and Oriental Medicine treatments and other procedures associated with the practice of traditional Oriental Medicine provided by the clinical staff. I have discussed the nature and purpose of my treatment with the clinical staff.

I understand that methods of treatment include but are not limited to: acupuncture, acupressure, moxibustion, cupping, gua sha, electrical stimulation, dietary advice and nutritional counseling, and bodywork therapies such as Amma Therapeutic Massage, Tui Na (Chinese Massage), Sotai and Shiatsu.

I am aware that acupuncture and Oriental Medicine treatments can have side effects such as bleeding or bruising , dizziness and fainting, and burns.

I recognize that there are rare but potential risks involved with acupuncture such as spontaneous miscarriage, nerve damage and organ puncture as well as infection.

I also recognize that while Oriental Medicine therapy provides the potential benefits of painless and drug-free relief of my presenting condition and prevention of recurrence, there is no implicit guarantee of a cure from this therapeutic approach.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had the 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.

_____	_____
Date	**Printed name Staff**
_____	_____
Printed Name of Patient	**Signature of Staff**
_____	
Signature of Patient	
_____	
Patient Rep. if applicable	