CONSENT FOR EXAMINATION AND TREATMENT

I acknowledge that during the course of my care I (or the person named below for whom I am legally responsible) may receive acupuncture and other oriental medicine procedures.

I understand that, as in the practice of medicine, in the practice of other clinical therapies there are some risks to treatment. I understand that if acupuncture and oriental medicine treatments the risks include but are not limited to: minor bleeding, local bruising, fainting, temporary pain and discomfort and the possible temporary aggravation of prior existing symptoms.

I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on her to exercise judgment during the course of the procedure which he or she feels at the time, based on the facts then known, is in my best interests.

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

_____
Patient's name (Please Print)

_____ _____
Signature of patient Date
(or guardian if patient is a minor)