

Clear Choice Acupuncture and Wellness

213 N Thompson St., Conroe, Texas 77301

936-689-6975

Informed Consent to Oriental Medical Health Care

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by the licensed acupuncturist on staff at Clear Choice Acupuncture and Wellness who now or in the future treat me while employed by, working or associated with Clear Choice Acupuncture; acupuncture and other Oriental Medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle and orthopedic testing; modes of manual or physical therapy such as body work, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation; cupping and/or moxibustion; the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendations; exercise advice and healthy lifestyle recommendations.

I understand I have the opportunity to discuss with my practitioner the nature and purpose of acupuncture and Oriental Medical procedures. Although I am aware that acupuncture and the other procedures used in Oriental Medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of conventional Western Medicine, in the practice of Oriental medicine there are some risks to treatment. I understand that these risks include but are not limited to: bleeding, bruising, pain and other strong sensation at the location of where a needle is inserted or radiating from that location, nerve pain, burns, aggravation of current symptoms, appearance of new symptoms and general aches. Other uncommon but possible risks include pneumothorax (punctured lung), puncture of other organs, spontaneous miscarriage, sprains, strains, dislocation, fractures, disc injuries and strokes. I do not expect the practitioners to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioners to exercise such judgment, during the course of my treatment, as the practitioner feels at the time, based on the facts then known, to be in my best interest. I am also aware that I am not to move or change positions during a treatment.

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I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures and conditions of treatment. 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 with Clear Choice Acupuncture and Wellness.

Print Patient Name

Date

Patient Signature

Print Patient's Representative Name (if applicable)

Date

Signature of Patient's Representative (if applicable)