

Xue Clinic

INFORMED CONSENT FOR TREATMENT

I consent to acupuncture treatment and other procedures associated with Traditional Chinese Medicine by Dr. Chulong Xue. I have discussed the nature and purpose of my treatment with Dr. Xue.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tuina (Chinese massage), Chinese or Western herbal medicine, and nutritional counseling.

Acupuncture has the effect of normalizing physiological functions, modifying the perception of pain, and treating certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising, tingling, or numbness near the needling sites, which may last a few days. There have been very rare instances reported of fainting, infection, and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy.

I understand that the herbs need to be prepared, and the tea consumed, according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of Xue Clinic of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I will notify the Clinic Medical Staff member who is caring for me if I am or become pregnant.

I do not expect the Clinic Medical Staff to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on the Clinic Medical Staff to exercise judgment during the course of treatment that the Clinic Medical Staff thinks at the time, based upon the facts then known, and is in my best interest.

I understand that the Clinical Medical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below I show that I have read, or had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. No guarantee has been made. 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 or by patient's representative if the patient is a minor or is physically or legally incapacitated)

Print name of patient _____

Signature of Patient (or Representative) _____

Date signed ----- / ----- / -----

(To be completed by the member of the Clinical Medical Staff providing information and obtaining consent.)

Print name of Clinic Medical Staff _____

Signature of Clinical Staff _____

Date signed ----- / ----- / -----