SILVER LEAF ACUPUNCTURE LLC.

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments, and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who treat me while working with Silver Leaf Acupuncture, whether signatories to this form or not.

I understand that the methods of treatment may include acupuncture, Chinese herbs, moxibustion, cupping, electrical stimulation, massage, and nutritional counseling.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling site that may last a few days, and dizziness or fainting. Unusual risk of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles, and maintains a clean and safe environment.

Potential risks of moxibustion, cupping, and heat lamps are burns and/or scarring. Bruising is a common side effect of cupping.

I understand that while this document describes the major risks of treatment, other side effects or risks may occur. I will notify a clinical staff member who is caring for me if I am or become ***pregnant***.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand that the clinical and administrative staff may review my patient 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 have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an 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.

PATIENT NAME (or representative): ______________________________

PATIENT SIGNATURE (or representative)**:** ______________________________

Date: ______________________________