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Patient Information & Informed Consent Form

I, the undersigned, understand that the treating doctor is a practitioner of Oriental Medicine and licensed to practice in this state. I voluntarily consent for treatment and understand that treatment may include, and not limited to: the use of acupuncture needles, various forms of moxabustion therapy, laser acupuncture, cupping, mineral heat lamps, herbal formulas, acupressure, psychological advice, tui na (Chinese massage), electrical stimulation, hot and cold packs, homeopathy, supplements, and diet and nutritional counseling.

I fully understand that the means and risks of treatments in Oriental medicine, although limited, could include the following; bruising, puncturing organs in the abdomen or chest cavities, shock induced by needle stimulation, premature labor in pregnant females, herbal side effects, drug interactions or allergic reactions. If I use a pacemaker, have heart problems, have metal plates or rods in my body, have an infectious disease, am taking herbs, medications, supplement, or any drugs, or suspect that I am pregnant, I agree that I will inform my practitioner before beginning the treatment. I understand that slight bruising from cupping or needles may be a normal side effect and that supplements and herbs will be administered as prescribed by the treating doctor.

I understand treatments of oriental medicine may affect people differently on various levels: physical, emotional, mental and spiritual, because it works within the entire body to restore balance. I understand that the duration of treatment varies person to person depending on a variety of factors such as the illness, duration, severity and body constitution. I fully understand that there is no stated or implied guarantee of success of effectiveness after a specific treatment or series of treatments, and I do not hold The Center: Natural Health Specialists and those affiliated with The Center: Natural Health Specialists responsible for any risks that may come about due to treatment. I have completed the patient information form truthfully, completely and accurately, and understand and accept the risks involved in treatment.

I consent that practitioners at The Center: Natural Health Specialists may duplicate medical records, collaborate and share my health information, and be updated on progress reports with other practitioners participating in my health care at The Center: Natural Health Specialists and/or the referring health care practitioner(s).

I understand that the doctor is not providing western (allopathic) medical care, and that I should look to my Western primary care physician for those services and routine check-ups. The doctor has discussed the information contained within this form, and I understand this information.

I further understand that there is a charge of $25.00 for any returned checks, and that full treatment costs will be charged for any missed appointments without prior 24 hour notification.

Printed Name:_____ Date _____

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Patient Signature (Parent or Guardian if under 18)