INFORMED CONSENT TO RECEIVE TREATMENT AND CARE

For your protection and the protection of your physician, California laws give patients the right to know about the treatment they receive. Sometimes, good practice requires that we tell you about risks associated with the treatment or the use of medication, as well as the limitations of both. You are always welcome to ask for more details if you wish.

Left Coast Acupuncture, practices Traditional Chinese Medicine, Acupuncture, Herbal Medicine, and Oriental Medicine, which is a Complementary and Alternative Medicine. Each patient is treated as an individual and there is no “one size fits all” course of diagnosis or treatment. Lake Merritt Acupuncture physicians will consider CAM(Complementary and Alternative Medicine) modalities, possible recommending one or more practices, diagnostic’s, or remedies.

The CAM practices utilized may include, but are not limited to, one or more of the following: acupuncture, dietary supplements, herbal remedies, exercise, lifestyle counseling, medicinal use of nutrition, massage, cupping, gua sha, moxibustion, stretching, physical manipulation, electrical muscle stimulation, mind body techniques, needle retention, tui na, electrical, laser, and or magnetic stimulation, micropuncture (bleeding therapy), diagnostic palpation on various areas of my body, and other energy therapies.

I understand that the diagnosis given to me conforms to the principals of Traditional Chinese Medicine (TCM), and in no way purports to replace allopathic medical evaluation, diagnosis, or treatment.

I have provided a full history and description of the complaints and health status which is complete and accurate. I understand that the need for communication with all of my health care providers regarding my health status is ongoing and necessary.

I understand that no guarantee has been made concerning the use and effects of TCM. I understand that in some cases, symptoms may relapse or intensify temporarily during the course of treatment before relief is sustained.

I understand that I may stop treatment at anytime.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

Acupuncture: I understand that it is a technique using small, sterile, stainless steel needles inserted at specific points in the body, causing a positive response in order to correct various ailments. Only disposable needles are used. The location and the application of the needles and the depth of the needle insertion is determined by the nature of the problem. I understand that the application of these needles may be accompanied by a brief painful sensation, and that there is a slight possibility of minor

swelling, bleeding, discoloration of the skin, hematoma, a bruise at the site of needling, or fainting. Momentary euphoria or light headedness may occur ofter treatment. The attending acupuncturist can easily handle any immediately reported problems that arise from the acupuncture treatment, and the possibility of minor problems need not be a cause of concern. Some very rare risks of acupuncture include pneumothorax and infection. Burns and or scarring are a potential risk of indirect moxibustion. Rarely, massage and bodywork may cause a temporary increase of symptoms or new symptoms may present.

Moxibustion: I understand that this is the application of indirect heat supplied by burning the her Folium Artemesiae Vulgaris over a single acupuncture point or a group of points. this generally produces a pleasurable sensation of relaxation. The area being treated may remain red and warm for several hours after treatment. In rare incidences, a minor burn may occur at the site of moxibustion. the attending physician can easily address this.

Cupping: I understand it uses round vacuum cups over a large muscular area, such as the back to enhance blood circulation to the designated area. this method may produce a deep redness, discoloration and on rare occasions, a minor blister which may persist for up to a week. These marks may resole on their own and are not indications of complications or injuries.

Qi Gong: Chinese for “energy work”, I understand it is a non invasive healing modality that predates the use of acupuncture needles, and incorporates the same therapeutic basis as acupuncture.

Acupressure/Tui Na Massage: I understand that I may also be given acupressure massage as part of my treatment to modify or prevent pain perception and to normalize the body’s physiologic functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of the symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Herbs and Nutritional Supplements: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction, to modify or prevent pain perception, and to normalize the body’s physiological functions. Herbs are used to facilitate the body’s own restorative process. The herbs are usually taken in tea form or mixing powdered granules. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them.

I understand that recommended herbs are traditionally considered safe in the practice of TCM, although some may be toxic in large doses. I understand that some dietary supplements are inappropriate during pregnancy, may interact with medications or other supplements, may have side effects of their own, or may contain potentially harmful ingredients not listed on the label. I also understand that most supplements have not

been tested in pregnant women, nursing mothers, or children. Potential risks include but are not limited to: allergic reactions, nausea, gas, stomachache, vomiting, headache, diarrhea, rash, hives, and tingling of the tongue. Some possible side effects of applying topical creams, liniments, ointments and plasters are rashes, hives and tingling of the skin. I will immediately notify my physician if any unanticipated or unpleasant effects associated with the consumption of herbal teas, tinctures, topical creams, or patent (pill form) medicine.

I understand that Left Coast Acupuncture physicians cannot be expected to anticipate and explain all risks and complications. I understand and agree that my physician will exercise judgement during the course of treatment which they feel at the time, based on the facts known then, is in the best interest of me as the patient.

Contraindications for acupuncture treatment and certain herbs include a history of a bleeding disorder or current anticoagulant therapy, and implanted pacemaker or prosthetic heart valve, use of certain medications, and/ or pregnancy.

Potential benefits of treatment include but are not limited to: restoration of health and the body's maximum functional capacity without the use of drugs or surgery; relief of pain and symptoms of disease; assistance in injury and disease recovery; and prevention of disease or it's progression.

Privacy: I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself, or my representative, or unless required by law.

I understand that Left Coast Acupuncture applies reasonable safeguards to protect my Person Health Information.

Patient Authorization and Consent for Treatment

I herby state that I have read and understand this form, that I have been given an opportunity to ask questions, and that all questions have been answered in a satisfactory manner: and I understand that I am free to withdraw my consent to treatment at any time, and that this consent will remain in effect until such a time that I make known that I choose to terminate it. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Left Coast Acupuncture Physician Name: Thomas Cobb MS L.Ac.

Patient Name _____

Signature of Patient _____
(or person authorized to consent)

Date_____

CONSENT TO TREAT A MINOR CHILD

I authorize, Left Coast Acupuncture, to treat _____(name)

who is my _____(relationship)

Adult's Signature_____Date_____