Informed Consent

I hereby request and consent to acupuncture, herbal treatment and any other procedure within the scope of Traditional Chinese Medicine, on me (or the patient named below, for whom I am legally responsible) by Moss Andrewes, D.Ac, or another qualified acupuncturist at this facility.

Acupuncture: I understand the methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping or electric stimulation. I have been informed that acupuncture is a generally safe method of treatment, but that I may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including pneumothorax. Infection is another possible risk, although the practitioner uses sterile, disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping.

Herbal Medicine: I understand the methods of treatment may include, but are not limited to herbal medicine and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally or in writing. These herbs may have an unpleasant smell or taste. I will immediately inform the clinical staff of any unanticipated effects from the herbs. The herbs and supplements I have been recommended to use are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses or taken without proper medical consultation by the prescribing party (as with all medications). I understand that some herbs may be inappropriate during pregnancy. Some unusual but possible side effects of taking herbs are nausea, gas, stomach ache, vomiting, headache, diarrhea, rashes, hives and/or tingling of the tongue. I will notify the clinical staff if I become pregnant.

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

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on them to exercise judgment during the course of treatment, which they think, at the time, based upon the facts then known, that is in my best interest.

I understand the results are not guaranteed. I understand the clinical and administrative staff may review my patient records and lab reports, but all records will be kept confidential and will not be released without my written consent.

The wellness support Moss offers to her patients includes a weekly e-newsletter on healthy living. By giving your email address, you are consenting to receive this newsletter. You may unsubscribe from the newsletter at any time. If you DO NOT want to receive this service, please check this box: ❑

I, _____have read, understood and completed, to the best of my knowledge, the History form and the Informed Consent form. I release the clinical staff from any and all liability from problems arising from the treatment as a result of information not given or incorrectly given in this history.

Patient Signature:_____ Date:_____

Clinical Staff Member: _____

Signature: ___________________________ Date: ________________________