WASHINGTON STATE ACUPUNCTURE & CHINESE MEDICINE CENTER

Raymond Chan, LEAMP Bing Su, LEAMP Corey Ojima, ND, LEAMP

Pei-Hwa Lin, LEAMP, MAcOM Shaobai Peter Zhang, LMT

663 S. KING STREET, SEATTLE, WA 98104-2937

PHONE: 206-292-9646 FAX: 206-292-9650

PATIENT CONSENT

The law requires patients receiving acupuncture to give their informed consent prior to receiving treatment. Informed consent is for the patient to be advised of the credentials of the practitioner(s) and the scope of the practice of acupuncture in the State of Washington.

The practitioners, **Raymond Y.T. Chan, LEAMP**, **Bing Su, LEAMP, Corey Ojima, ND, LEAMP, Pei-Hwa Lin, LEAMP, MAcOM and Shaobai Peter Zhang, LMT** are licensed in the State of Washington. As stated by law, therapy acupuncturists in the State of Washington are allowed to use the methods listed below. This in no way means that all these methods will actually be used for your treatment. You will be advised before any one of these methods is to be applied, and you always have the right to decline.

1. use of acupuncture needles to stimulate acupuncture points
2. use of electrical, magnetic, or mechanical devices to stimulate acupuncture points
3. moxibustion (direct or indirect application of heat on acupuncture points using herbal materials)
4. Tui Na (acupressure)
5. cupping
6. Gua Sha (dermal friction)
7. infra-red light
8. auricular acupuncture (ear), can be used as a substitute for body needling
9. sono-puncture (ultrasound) or laser puncture
10. Chinese herbal therapy and dietary advice based on traditional Chinese medical theory

Patients with the following conditions must inform the practitioner(s) prior to receiving acupuncture treatments. Please check the following that applies.

_____ Pregnancy
_____ Severe bleeding disorders
_____ Pacemaker
_____ Hepatitis
_____ AIDS or HIV positive

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 above named practitioner(s), or other licensed practitioners who now or in the future treat me while employed by, working or associated with or serving as back-up for the practitioner(s) above, including those working at the clinic or office listed above.

Potential and Unusual risks: 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 sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping and gua sha. Burns and/or scarring are a potential risk of moxibustion and cupping. Unusual risks 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. I understand that while this document describes the major risks of treatment, other side effect and risks may occur. 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 Oriental Medicine, although some may be toxic in large doses.

(please turn over)

PATIENT CONSENT (Cont'd)

Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant. I understand that some herbs may be inappropriate during pregnancy.

Potential Benefits: Improved balance of bodily energies, which can lead to relief of pain, symptoms of disease, assist in injury and disease recovery, and prevent of disease or its progression, restore of health and strengthen the constitution.

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

I understand the clinical and administrative staffs 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, the risks and benefits of acupuncture and other procedures. 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.

I understand that there is no guarantee implied or expressed regarding the success or effectiveness of a treatment or a series of treatments. I hereby release **Raymond Y.T. Chan, LEAMP, Bing Su, LEMAP, Corey Ojima, ND, LEAMP, Pei-Hwa Lin, LEAMP, MAcOM and Shaobai Peter Zhang, LMT** and the assistant(s) under the supervision of him or her, from all liability in connection with these treatments. I understand that I am free to withdraw my consent and stop treatment at any time.

Patient Signature: _____

Guardian signature if under age 18

Patient Name (please print): _____

Date: _____

Clinic & Payment Policy

I have read, understand and agree to the Clinic and Payment Policy.

_____

Initials + Date

Financial Hardship

I request discounted fee due to financial hardship.

_____

Initials + Date