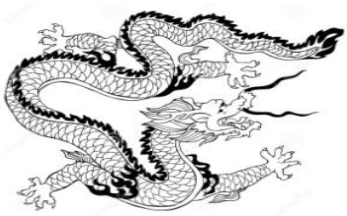

Lifecare Acupuncture

2166 Hayes Street, Suite 306
San Francisco, CA 94117
415-518-8100
acuval@sfsu.edu
http://www.lifecareacupuncture.com

I hereby request and consent to the performance of acupuncture and other Traditional Chinese Medicine (TCM) treatments on me _____ or the patient _____ who I am legally responsible for, by the licensed acupuncturist who now or in the future treatment and continuing care at *Lifecare Acupuncture*.

I understand that the scope of the practice includes but is not limited to:

- **Acupuncture**
- **Herbal therapy**
- **Other Oriental Medical Procedures including Diagnostic Techniques**
  - **Questioning**
  - **Pulse evaluation**
  - **Palpation on varieties of areas of the body**
  - **Observation**
  - **Range of motion**
  - **Muscle and Orthopedic testing**
  - **Modes of manual physical therapy such as massage**
  - **Manipulation of joints**
  - **Viscera**
  - **Heat and/or cold therapy**
  - **Electrical and/or magnetic stimulation**
  - **Prescription of herbal and homeopathic medicines**
  - **Dietary supplements**
  - **Dietary recommendations**
  - **Exercise**
  - **Discussion and advice regarding thoughts, feelings, sensations, emotions and attitudes**
  - **Healthy life style counseling**

I understand and am informed that, as in the practice of allopathic medicine, in the practice of Oriental Medicine there are some risks with treatment. I understand that although the risks of avert side effects can be minimal, they are possible. This could include, but are not limited to:

- **Bruising**
- **Bleeding**
- **Skin irritation**
- **Pain in the treated area**
- **Muscle weakness and/or soreness**
- **Brief generalized fatigue and/or nausea**
- **Sensations of heat or cold**
- **Tingling or numbness**
- **Brief lightheadedness or fainting**
- **Broken needles and risks of infection or pneumothorax**
- **Possible aggravation of symptoms existing prior to acupuncture treatment or creation of new symptoms**

I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

By signing this consent form, I acknowledge that I have read this formed consent form or have been read to me, and I fully understand the nature, purpose and risks of acupuncture and other Oriental Medical Procedures. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications associated with treatment at *Lifecare Acupuncture*. I wish to rely on my acupuncturist and their judgment in my best interest, based on the facts I have given them, during the entire course of treatment. I have had an opportunity to ask questions about this form's content and by signing below I agree to the named procedures mentioned above. I intend this consent form to cover the entire course of treatment for my present and any future conditions for which I seek treatment at *Lifecare Acupuncture*.

A record is made each time you visit *Lifecare Acupuncture*. Your symptoms, the acupuncturist's judgment, and a plan of treatment recorded. This record serves as a basis for planning your care and treatment at future visits. Your health record is the physical property of *Lifecare Acupuncture*, but the content is about you and therefore belongs to you. You have the right to review or obtain a paper copy of your health record. You have the right to request restriction on certain uses and disclosure of your information. By signing this consent form, you agree that you may be contacted by staff members in regards to appointments or information related to treatments. If this contact is unavailable by phone, the staff member may leave a message with an answering machine or anyone who answers the phone.

***Lifecare Acupuncture* is required to maintain the privacy of your health information with this notice of our privacy practices. We are required to follow the terms of this notice and to notify you if we are unable to grant your request to disclosure or restrict disclosure of our health information to others. Other than for the reasons described in this notice, this clinic agrees not to use or disclose your health information without your authorization.**

By signing this consent form, I acknowledge that I have read or it has been read to me and fully understand the Privacy Practice regarding disclosure and patient health information.

_____

Signature

_____

Printed Name

_____

Signature of Patient's Representative

_____

Printed Name of Patient's Representative

_____

Relationship or Authority of Patient's Representative

_____

Date Signed