Morningsun Health Care

INFORMED CONSENT FOR TREATMENT

I consent to acupuncture treatment and other procedures associated with Traditional Chinese Medicine by Dr. Qinyu Wang. I have discussed the nature and purpose of my treatment with Dr. Wang.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Acupressure, Chinese herbal medicine, and nutritional counseling.

Acupuncture has the effect of normalizing physiological functions, modifying the perception of pain, and treating certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising, tingling, or numbness near the needling sites, which may last a few days. There have been very rare instances reported of fainting, infection, and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

The herbs (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand that the herbs need to be prepared, and the tea consumed, according to the instructions provided orally and/or in writing. The herbs may have an unpleasant smell or taste. I will immediately notify Dr. Qinyu Wang of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I understand that the Clinical Medical staff may review my medical 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 had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. No guarantee has been made. 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.

(To be completed by patient or by patient's representative if the patient is a minor or is physically or legally incapacitated)

Print Name of Patient

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Print Name of Clinic Medical Staff

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Signature of Patient (or Representative)

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Signature of Clinic Medical Staff

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Date Consent Completed

_____

Print Name / Signature of Translator if any

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