INFORMED CONSENT FOR ORIENTAL MEDICAL TREATMENT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of Oriental medicine on me (or on the patient named below for whom I am legally responsible) by the Licensed Acupuncturists named below and/or other Licensed Acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the practitioners named below, including those working at Acupuncture West, LLC or any other office or clinic, whether signatories to this form or not.

There are some risks to treatment, including but not limited to some bruising of the skin and/or slight bleeding. If moxibustion or heat therapies are used there is a risk of burn and/or scarring. The risk of infection is small when all needles are sterile and Clean Needle Technique procedures are followed. I understand that all practitioners at Acupuncture West, LLC are certified in Clean Needle Technique and use only sterile, single-use, disposable needles.

I have had an opportunity to discuss with the practitioner the nature and purpose of Oriental medicine. I understand that results are not guaranteed.

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

I understand that I have the choice to accept or reject the proposed diagnostic procedure or treatment, or any part of it, before or during the diagnosis or treatment.

I understand that the practitioner is not providing Western (allopathic) medical care, and that I should look to my Western primary care practitioner (i.e. MD) for those services and for routine check-ups.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named 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.

PATIENT SIGNATURE:
(Or Patient Representative)

DATE: **X** (Indicate Relationship If Signing For Patient)

Peter Games, L. Ac. Jennifer Games, PT, L. Ac.
Acupuncture West, LLC 6003 Overland Road, Suite 203 Boise, ID 83709 (208) 377-1455