INFORMED CONSENT

I voluntarily consent to be treated by the LA Torrance Acupuncture Chinese Medicine. The Clinic offers several treatment modalities. The course of the treatment will be determined between the health practitioner and myself.

The treatments consist of, but are not limited to:

1. The use of acupuncture needles to stimulate acupuncture points and meridians
2. Use of electrical, mechanical, or devises to stimulate acupuncture points and meridians
3. Indirect Moxibustion
4. Acupressure
5. Cupping
6. TuiNa
7. Infra-red Heat Lamp
8. Traditional Chinese Herbal Supplements
9. Dietary advice based on traditional Chinese medical theory
10. Facial Rejuvenation

I acknowledge that there are some risks to the treatment. These side effects may include, but are not limited to the following:

1. Some pain following treatment in the insertion area
2. Minor bruising
3. Infection
4. Needle sickness
5. Patients with severe bleeding disorders or pace makers should inform the practitioner prior to any treatment.

If you are pregnant or have a history of seizures, you should also inform the practitioner.

I understand that there is neither an implied nor stated guarantee of success of effectiveness of a specific treatment of series of treatments. I understand that all my questions regarding the procedure will be answered, and that I am free to withdraw my consent and to discontinue treatment at any time.

I hereby authorize the LA Torrance Acupuncture Chinese Herbal Medicine to release any information regarding my condition to the referring physician (if any) and/or to my insurance for the processing of any claim. With notification, I also authorize the LA Torrance Acupuncture Chinese Herbal Medicine to obtain my medical records from other physicians or medical centers.

Payment in full is expected at the time of each appointment. The clinic will help you in preparing the necessary papers for your insurance. I agree to give 24 hours notice to the clinic if I must cancel or re-schedule an appointment. I understand that I will be charged at current clinical rates after 3 missed appointments when no notice is given or for failing to show up to the appointment. Exceptions may be made in a case of an emergency. I understand that in case of unavoidable lateness by me or by the clinic, the schedule may be adjusted to provide for my treatment in its entirety.

Thank you for you cooperation and consideration.

Signature_____Date_____

Patients Representative or Parent_____

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