



**INFORMED CONSENT TO ACUPUNCTURE, CHINESE HERBAL MEDICINE & TRADITIONAL CHINESE MEDICINE (TCM) CARE**

While acupuncture treatments and other Traditional Chinese Medicine (TCM) modalities have been proven to be highly effective in correcting a variety of disorders and maintaining overall well-being, Registered Acupuncturists and TCM Practitioners in BC are required to advise patients of the potential risks. Acupuncturists or TCM Practitioners cannot anticipate all the possible risks and complications that may arise with each individual case; however, you should be aware that the following side effects may occur: bruising, minor bleeding, numbness or tingling at or near the needling sites that may last for a few days; light-headedness or dizziness may happen occasionally or even fainting very rarely; burns and scarring are potential risks of Moxibustion; bruising can occur after cupping or Gua Sha scraping treatment. Some symptoms may worsen at the beginning of treatment. If the symptoms worsen and persist for more than 2 days, please inform your Registered Acupuncturist or Registered TCM Practitioner. In very rare instances, spontaneous miscarriage and pneumothorax have been reported.

**Statement of Consent (Please circle the appropriate practitioner name, sign and fill in the blanks below)**

I have read and understood the possible risks of treatment outlined above, but do not expect the Acupuncturist or TCM Practitioner to be able to anticipate and explain all possible risks and complications arising as a result of the treatment.

I understand that my Registered Acupuncturist or TCM Practitioner may review my medical records and lab reports, but all my records will be kept strictly private and confidential and will not be released without my written consent. I also understand that it may be necessary for my acupuncturist or TCM practitioner to communicate with another health care professional regarding my treatment.

I consent to acupuncture treatments, which may include acupuncture needling, Moxibustion, cupping, Gua Sha scraping, reflexology, electro-acupuncture, laser acupuncture, point injection therapy, Tui Na massage, and other TCM therapies, by my Registered Acupuncturist or Registered TCM Practitioner. I understand that there are no guarantees regarding cure or improvement of my condition.

I understand that some herbs may be inappropriate during pregnancy if it is applicable to me. The herbs and nutritional supplements that are used are traditionally considered safe in the practice of Chinese Medicine. If I experience any gastrointestinal upset or allergic reactions to the herbs, I will stop taking them and immediately inform the TCM practitioner Bok Hing Chen.

**Point Injection Therapy** involves the use of intramuscular/intradermal injection of nutrients including amino acids, vitamins and sterile herbal substances into acupuncture points. I understand that these therapies may be used, upon my consent, to treat my condition. Side effects are rare, but may include allergic reactions, slight pain or stinging sensation at the site of the needle insertion, and bruising. Other rare risks include, but are not limited to: wheezing, rapid heart rhythm and elevated blood pressure. I understand the nature of the proposed procedure and the risks have been explained to me.

I hereby release my **Registered Acupuncturist & Theralase Laser Rehabilitation Therapist Manuela Miutescu or Registered TCM Practitioner Bok Hing Chen** from all liability which may occur in connection with the above mentioned procedures. I understand that I may withdraw my consent and refuse treatment at any time. I intend this consent form to cover the entire course of treatment for my present condition and further conditions for which I seek treatment.

**Royal Treatment Therapeutics**

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**Cancellation Policy:**

In consideration of other patients and my therapist, I understand that a minimum of **48 hours'** notice is required to change or cancel my appointment. **I am aware that it is my responsibility to pay 100% of the treatment fee in the case of late cancellations or missed appointments.** By signing below you understand and agree to our cancellation policy.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ (YYYY/MM/DD)

**Consent of Treatment:**

I confirm the health and medical information given above to be accurate. As well, I understand the therapeutic benefits and possible side-effects of the treatment that may be recommended for my condition and for any future conditions for which I seek treatment, and I consent to the proposed treatment.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship of Legal Guardian

\_\_\_\_\_  
Signed Date