



Patient Information and Informed Consent Form

I, the undersigned, understand that the treating practitioner is a Licensed Acupuncturist and Herbalist the state of North Carolina. I voluntarily consent for treatment and understand that treatment may include, but is not limited to: the use of acupuncture needles, various forms of moxabustion therapy, cupping, mineral heat lamps, herbal formulas, acupressure, magnets, tui na (Chinese Massage), electrical stimulation, homeopathy, supplements and diet and nutritional counseling.

I fully understand that the risks of treatment in Oriental Medicine, although limited, could include the following: burns, bruising, puncturing organs in the abdominal or chest cavities, shock induced by needle stimulation, premature labor in pregnant females, herbal side effects, drug interactions or allergic reactions. If I use a pacemaker, have heart problems, have metal plates or rods in my body, have an infectious disease, am taking herbs, medications, supplements or any drugs, or suspect that I am pregnant, I agree that I will inform my practitioner before beginning the treatment. I understand that slight bruising from cupping or needles may be a normal side effect and that supplements and herbs will be administered as prescribed by the practitioner.

I understand treatments of Oriental Medicine may affect people differently. The duration of treatment varies, and there is no stated or implied guarantee of success or effectiveness after a specific treatment or series of treatments. I do not hold Oriental Medicine and Therapeutics, LLC and those affiliated with Oriental Medicine and Therapeutics or Inside Out Body Therapies responsible for any risks that may result due to treatment. I have completed the patient information form completely and accurately, and I understand and accept the risks involved in treatment.

I understand that Oriental Medicine is complimentary health care system and that the practitioner is not providing western (allopathic) medical care. I understand the need to maintain a relationship with my primary care physician to ensure my comprehensive health care needs are met. The practitioner has discussed the information contained within this form, and I understand this information.

I further understand that there is a charge of \$25.00 for any returned checks, and that full treatment costs will be charged for any missed appointments without prior 24 hour notification.

Printed Name: _____

Patient Signature (Parent or Guardian if under 18 years of age)

Date: _____