



Michael Cote, R.Ac

Acupuncturist /Traditional Chinese Medicine

Consent Form

I hereby request and consent to the performance of acupuncture and other procedures within the scope of traditional Chinese medicine (TCM) by the person named below. I understand that the methods of treatment may include, but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, Chinese herbal patent medicine, and dietary recommendations.

I have been informed that acupuncture and TCM is generally a safe method of treatment, but that there may be side effects, including aggravation of pre-existing symptoms, bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. Allergic reactions to herbs are possible. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I understand that I should not make significant movements while the needles are being inserted, retained, or removed. I also understand that I may be required to remove articles of clothing to facilitate access to areas of the body requiring treatment.

I will inform my acupuncturist, traditional Chinese medicine practitioner, or doctor of traditional Chinese medicine if I become pregnant or am trying to become pregnant so as to help minimize risks of TCM to the pregnancy.

I do not expect the acupuncturist, traditional Chinese medicine practitioner, or doctor of traditional Chinese medicine, to be able to anticipate and explain all possible risks and complications. I wish to rely on the person named below to exercise judgement during the course of the treatment which he/she feels at the time, based upon the facts then known, is in my best interests. I understand that results are not guaranteed.

I understand that a record will be kept of the services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless law requires it. I understand that I may look at my patient file at anytime and can request a copy of it by paying the appropriate photocopying fee. I understand that information from my medical record may be analyzed for research purposes but that my identity will be protected and kept confidential.

I understand that I will be responsible for payment of my account at the time of service. Missed appointments hurt the clinic and other patients that could have been seen at that time; therefore, I will give 24 hours notice to cancel or reschedule an appointment and understand that I will be charged \$35 for sessions missed without sufficient notice.

I have read, or have had read to me, and understand the above. I have also had an opportunity to ask questions about its content. By voluntarily signing below, I agree to the above named procedures except for: _____. I intend this consent form to cover the entire course of treatment and for any future condition(s) in which I seek treatment. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Print Name

Signature

Date

Michael Cote, R.Ac
R.Ac., TCM.P, or D.TCM

Signature of R.Ac, TCM.P, or D.TCM