

Informed Consent to Treat

I hereby request and consent to the performance of any style of Traditional Chinese Medicine (TCM) including acupuncture and Chinese Herbal Medicine treatments and other procedures within the scope of the practice of acupuncture on me, (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while working or are associated with, or serve as a backup for the acupuncturist named below, including those working at this office or any other office, whether signatories to this form or not.

I understand that methods of acupuncture treatment may include, but are not limited to, acupuncture, moxibustion, cupping, gua sha, electrical stimulation, bloodletting, Chinese or Western herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling site that may last a few days, and dizziness or fainting. I understand that I should not make significant movements while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses only sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of natural medicine within the dose prescribed. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant or if I experience any side effects from an herb formula or supplement I have been prescribed.

In regards to the current epidemic outbreak of COVID-19, I will receive treatment to generally improve the health of my immune system and overall well-being, according to the experience and knowledge from my clinician and the recommendations from their Chinese TCM colleagues who have been working with corresponding COVID-19 medical conditions in China. I understand none of these treatments have been approved by the Centers for Disease Control or the FDA to prevent, cure, or treat COVID-19. In the event that I may have been exposed to, or have contracted COVID-19, I will inform my clinician and contact my physician immediately.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment, which the clinical staff thinks at the time, based upon the facts, then is applied in my best interest. I understand that results are not guaranteed. I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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 _____

Practitioner signature _____

Date _____

COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office’s roles to provide me with information to assist me in making informed choices. This process is often referred to as “informed consent” and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted.
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary. I understand there are alternatives to receiving this care, which could including receiving care from another type of provider, or postponing care altogether at this time. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time.
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office.

• I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:

- | | | |
|--------------------|-----------------------------|--------------------------------|
| *Fever | *Shortness of Breath | *Dry Cough |
| *Runny Nose | *Sore Throat | *Loss of Taste or Smell |

- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline.
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care.
- I have been offered a copy of this consent form.

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient signature _____
(Or Patient Representative)

Date _____

Practitioner signature _____

Date _____