I hereby request and consent to the performance of acupuncture 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 treats me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I realize that acupuncture may be considered as an investigative procedure in the United States. There are some risks to treatment, including but not limited to some bruising of the skin and/or slight bleeding. The risk of infection is small where as all needles are sterile. Needles are considered sterile when they are either disposable or are autoclaved according to California State Board requirements.

I have had an opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture. I understand the results are not guaranteed.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications. I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in the best of my interest.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

To be completed by the patient:

_____ _____

Print Patient's Name Signature of Patient Date

To be completed by patient's representative, if necessary, e.g. patient is a minor or physically or legally incapacitated:

_____ _____

Print Patient's Name Print Name of Patient's Representative

As: _____ _____

Relationship or authority of Patients Representative

Signature of Patient's Representative

_____

Date

Translated by: _____

Date

The signed original is to be filed in patient's file and a copy is to be given to the patient