future MEDICINE *now*

LARRY HORTON :: SUE SWANBACK

doctors of oriental medicine

Informed Consent

I hereby request and consent to the performance of the following diagnostic techniques and treatment modalities of oriental medicine on me (or on the patient named below, for whom I am legally responsible): acupuncture and other oriental medical procedures; injection therapy; intravenous therapy; manual palpation on a variety of areas of my body; muscle, orthopedic and neurologic testing; modes of physical therapy such as massage; heat and/or cold therapy; electrical and/or magnetic stimulation; the prescription of herbal and homeopathic medicines, as well as dietary supplements; dietary recommendations; bioidentical hormones; exercise regimens; and lifestyle counseling

I have had the opportunity to discuss with the doctor and/or with staff the nature and purpose of acupuncture and oriental medical procedures. I understand that, although oriental medical procedures have helped millions of people, no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of conventional medicine, there are some risks to treatment in the practice of oriental medicine. I understand that, while unlikely, possible risks include, but are not limited to: bleeding, bruising, puncture of various organs, pain or other strong sensations at the location of a needle insertion, nerve pain, burns, aggravation of current symptoms, and appearance of new symptoms. I do not expect the doctor to be able to anticipate and explain all risks and complications, and during the course of treatment I wish to rely on the doctor's judgement, based on the facts then known.

I have read, or have had read to me, the above consent. I have also had an 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 Patient:

____
Print Patient's Name

____
Signature of Patient

____
Date Signed

____
Witness

To be completed by patient's representative if patient is a minor or physically or legally handicapped:

____
Print Name of Patient's Representative

____
Signature of Patient's Representative

____
Relationship or Authority of Patient's Representative

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