INFORMED CONSENT

I hereby request and consent to the performance of acupuncture treatment and/or nutritional/herbal/ botanical therapy 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 working at San Jose Functional Medicine, whether signatories to this form or not.

I understand that the methods of treatment may include, but are not limited to, acupuncture, cupping, electrical stimulation, herbal/botanical and nutritional supplements, dietary and lifestyle therapy. I will notify a member of the clinic staff of any unanticipated or unpleasant effects associated with the consumption of these nutritional or botanical supplements. I will keep the clinic staff informed of any pharmaceutical drug or nutritional supplement, which I have been prescribed, or I am taking, in order to allow proper timing and dosage of these nutritional or botanical supplements.

The following paragraph applies only to patients receiving acupuncture therapy:

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last several 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, single-use, disposable needles and maintains a clean and safe environment. Burns and/or scarring are a possible risk of cupping. I understand that while this document describes the major risks of treatment, other risks may be present and other side effects may occur.

The following paragraph applies only to patients receiving nutritional/herbal therapy:

I understand that some herbs and nutritional supplements may be inappropriate during pregnancy. Some possible side effects of taking nutritional supplements are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I will notify the clinic staff member who is caring for me if I am or become pregnant.

The remainder of this informed consent applies to all patients:

I do not expect the clinical staff 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 all facts then known, is 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, the above 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 from this clinical staff.

Date

PATIENT SIGNATURE **X**

(or Patient Representative) (Indicate relationship if signing for patient)

Date

CLINIC SIGNATURE