SOUTH BAYLO UNIVERSITY CLINIC
www.southbaylo.edu/clinic
ANAHEIM CLINIC: 1126 North Brookhurst St. Anaheim, CA 92801 Phone: 714.533.3886 FAX: 714.520.0472
LOS ANGELES CLINIC: 2727 West 6th St. Los Angeles, CA 90057 Phone: 213.738.1974 FAX: 213.738.1923

DIVISION OF CLINICS
INFORMED CONSENT TO ACUPUNCTURE / ORIENTAL MEDICINE TREATMENT

I, _____ consent to Acupuncture/Oriental Medicine treatment(s) and other clinical procedure(s) provided to me by members of the Clinical Staff (Licensed Clinic Supervisor and Student Interns). I understand that the treatment plan provided to me nay include, but not limited to, Acupuncture needling, moxibustion, cupping, heat application, Tui-Na massage, Chinese herbal medicines and informal nutritional counseling.

I have been informed that Acupuncture needling is a safe therapeutic approach, however it may have side effects which may include bruising, numbness or tingling sensations as or near the needling site(s) lasting for a few days, and dizziness or fainting. Bruising is also a common outcome of cupping.

Unusual risks of acupuncture can include spontaneous miscarriage, nerve damage and organ puncture or lung puncture (pneumothorax). Infection is another potential risk, although the Division of the Clinics of the University uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring can be a potential risk of moxibustion. The herbal medicine and nutritional supplements, if any, that have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some of them may have toxic effects in large doses. Some possible side effects of taking herbal medicines can be nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling sensation of the tongue.

I also further understand that some of the herbal medicine prescriptions may be inappropriate during pregnancy. Thus, I will notify the Clinic Staff who is caring for me if I am or become pregnant.

I acknowledge that some of the herbal medicines need to be prepared and consumed according to the instructions provided orally and in writing. They may have an unpleasant smell or taste.

I do not expect the Clinic Staff to be able to anticipate and explain to me potential risks and possible complications of the treatment(s) I received, but I wish to rely on the Clinic Staff to exercise prudent judgment during the course of treatment which the Clinic Staff thinks at the time of treatment and based upon the clinical facts then known, to be in my best interest.

I fully understand that the Clinic Staff and University Administrative staff may review my medical records and related documents, but all my medical records will be kept confidential and will not be released to any party without my written consent.

By voluntarily signing this Informed Consent Form below, I acknowledge that I have read, or have had read to me, this Informed Consent to Treatment and that I have been advised about all risks and benefits of Acupuncture/Oriental Medicine procedures. Furthermore, I have had an opportunity to ask all relevant questions which were answered to me at my satisfaction.

I also understand that this Informed Consent to Treatment Form will cover the entire time I receive care for my present condition as well as for any future condition(s) for which I seek treatment at the University's Clinic.

_____	_____	_____
Patient's Name (print)	*Signature*	*Date*
_____	_____	_____
Clinic Supervisor's Name	*Signature*	*Date*