OAKLAND COMMUNITY ACUPUNCTURE

Patient Informed Consent:

I agree to receive acupuncture treatments and related therapies by Christopher Randle, L.Ac., Jennifer Taylor, L.Ac., Najia Kaddoura L.Ac., and Novella Leimberg L.Ac. Treatment methods may include, but are not limited to, acupuncture, Tui-Na massage and bodywork, cupping therapy, herbal medicine, nutritional supplements, heat and moxibustion therapy, electro-stimulation, physiotherapy exercises, as well as lifestyle and nutrition counseling.

I have been informed that acupuncture is very safe, but it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and in rare cases dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture. Infection is also a possible risk. However, I understand that Christopher Randle, L.Ac., Jennifer Taylor, L.Ac., Najia Kaddoura L.Ac., and Novella Leimberg L.Ac. use only sterile disposable single-use needles, and maintain a clean and safe environment. Tui-Na massage therapy is very safe but may lead to temporary muscle soreness, redness, or bruising. Burns and scarring are potential risks of heat or moxibustion therapy. Bruising is a common side effect of cupping.

The herbs and nutritional supplements used in Traditional Chinese Medicine are considered safe but may have potential side effects. I understand that some herbs may be toxic at large doses, and some herbs may be inappropriate to take during pregnancy. I will notify Christopher Randle, LAc., Jennifer Taylor L.Ac., Najia Kaddoura L.Ac., or Novella Leimberg L.Ac. immediately if I notice any unanticipated or unpleasant side effects associated with the consumption of herbal medicine or nutritional supplements.

I do not expect Christopher Randle, LAc., Jennifer Taylor, L.Ac., Najia Kaddoura L.Ac., or Novella Leimberg L.Ac. to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on them to exercise judgment during the course of treatment to make decisions that are in my best interest, based upon the facts then known.

I understand that the clinical and medical staff may review my files but all my records will be kept confidential and can only be released under my personal written consent, or when required by law.

If I am unable to make a pre-scheduled appointment, I agree to cancel at least 24 hours in advance. I understand that failure to do so will result in my being **charged the full amount** of the treatment price. I also understand that if I am more than 15 minutes late to an appointment, the remainder of the time-slot may be given to another patient.

By voluntarily signing below, I show that I have read (or have had read to me) and understood this consent to treatment. I have been told about the risks and benefits of acupuncture and related therapies and have had an opportunity to ask questions. This consent form shall cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment from Christopher Randle, L.Ac., Jennifer Taylor, L.Ac., Najia Kaddoura L.Ac., and/or Novella Leimberg L.Ac.

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Print Name of Patient (and Representative) _____

Print Name of Practitioner _____

X _____
Patient Signature/Date

_____
Practitioner Signature/Date