INFORMED CONSENT TO ORIENTAL MEDICAL HEALTH CARE

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by Michelle Weston, TxLAc. Acupuncture and other Oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle and orthopedic testing; modes of manual or physical therapy such as body work, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation; cupping and/or moxibustion; the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendations; exercise advice and healthy lifestyle recommendations. I understand I have opportunities to discuss the purpose of acupuncture and these Oriental medical procedures. Although I am aware that acupuncture and the other procedures used in Oriental medicine have helped millions of people, I understand that 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 Western medicine, in the practice of Oriental medicine there are some risks to treatment. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, pain or other strong sensation at the location of where a needle is inserted, or where cupping or herbal application is made to the skin, or radiating from those locations; nerve pain, tenderness, itching, burns, aggravation of current symptoms, appearance of new symptoms and red or purple marks from cupping. Other uncommon but possible risks include organ puncture, sprains, strains, dislocation, fractures, miscarriage, disc injuries and strokes. I do not expect the practitioner to be able to anticipate and explain all risks and complications. I wish to rely on her to exercise such judgment, during the course of my treatment, based on the facts then known, to be in my best interest. I authorize Michelle Weston to perform the necessary services during diagnosis and treatment. I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures and conditions of treatment. 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 with Michelle Weston.

_____

Patient's name (please print)

_____

Patient Signature Date

_____

Print Patient's Representative (if applicable) Relationship or Authority of Patient's Rep.

_____

Signature of Patient's Representative Date