DR. LESLIE YEDOR
INTEGRATIVE MEDICINE

Informed Consent

□ I hereby request and consent to acupuncture treatments and other procedures within the scope of the practice of acupuncture by the acupuncturist named below.

□ I understand that methods of treatment may include, but are not limited to, acupuncture, acupressure, moxa, tui-na (Chinese massage), cupping, gua sha, electrical stimulation, Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. I will immediately notify my acupuncturist of any adverse effects associated with the consumption of herbs prescribed.

□ I have been informed that these treatments are generally safe methods of care, but that they may have some side effects including bruising, numbness or tingling near the needling sites, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping and gua sha. 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 disposable needles and maintains procedures in accordance with California clean needle technique.

□ I understand that while this document describes the major risks of treatment, albeit rare. There are other side effects that may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, and rashes. I will notify my acupuncturist if I am or become pregnant.

□ I do not expect my acupuncturist to be able to anticipate and explain all possible risks and complications of treatments, and I wish to rely on my acupuncturist to exercise good judgment during the course of treatment. I understand that results are not guaranteed.

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.

Patient Name (print):_____ Date: _____

Patient Signature:_____ Date: _____

Guardian Signature:_____ Date: _____

Practitioner Signature:_____ Date: _____