RITACCO CHIROPRACTIC CLINIC, 800 Bathurst Street, Toronto, ON.

TCM ACUPUNCTURE INFORMED CONSENT TO TREATMENT

1. I understand that some of the techniques used under the scope of Traditional Chinese Medicine includes the use of sterile, single -use needles to penetrate the skin. Additional treatment methods can include, but are not limited to: acupuncture, acupressure, the electrical stimulation of needles, auricular magnets/seeds, cupping or moxibustion, gua sha, and Tuina. Before any of these procedures are performed, my practitioner will discuss my treatment options.

2. My practitioner has informed me of the risks and symptoms of treatment, which can include, but are not limited to: slight pain, light-headaches or nausea, soreness, bruising, bleeding or discolouration of the skin, and the possibility of other unforeseen risks and I freely accept the risks involved with my procedure

3. I will inform my practitioner if I currently have or develop any major health issues, if I suffer from any type of major bleeding disorder, or if I use a pacemaker.

4. I understand that I must let my practitioner know if I am carrying, or believe to have any infectious agents, including but are not limited to HIV, Tuberculosis, and Hepatitis. In some cases where cross-infection is high, my practitioner may withhold treatment.

5. I understand that there are no guarantees for the results of my treatments. Traditional Chinese Medicine does not often provide an instant cure. The length of my treatment depends on the severity of my condition. In some cases my symptoms may temporarily worsen before they begin to improve.

6. I understand that the fees charged for my treatments are no covered under OHIP and must be covered in full by myself or t through third party insurance. I am responsible for the full payment after services have been rendered.

I_____, have discussed with my Traditional Chinese Medicine Practitioner or, Acupuncturist the specifics of my assessment or treatment and understand the nature, risks and reasons for this procedure. I voluntary consent t Traditional Chinese Medicine/Acupuncture. I understand that I may withdraw my consent and halt my participation at any time

Patient signature_____Date_____

Practitioner signature_____Date_____