Yens Acupuncture & TCM

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INFORMED CONSENT FOR TREATMENT
PLEASE READ BEFORE SIGNING

I, _____ hereby request and consent to be treated with Acupuncture and/or other procedures within the scope of the practice of acupuncture on me (or on the patient name below, for whom I am legally responsible) by Peichen Yen who is Licensed Acupuncturist in the State of Virginia, California and Florida.

I understand that the herbs may need to be prepared and consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that Acupuncture is a safe method of treatment and only pre-sterilized, disposable needles will be used. "MOXA" or Cupping therapy may also be used. I understand that the treatments may have temporary side effects, including localized pain, numbness or tingling near the needling sites, bruising, or light headaches. I understand that I should not move while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping.

I accept the fact that no guarantee is made concerning the outcome of my Acupuncture treatments and/or herbal medicines or other treatment methods. I accept the fact that each combination of herbs is designed for my needs and my needs only, and therefore I cannot receive a refund on any herbs and any services. I also understand that I may stop treatment at any time. I will notify the Doctor if I am or become pregnant.

Payment must be made in full at the time of treatment.

By signing below I show that I have read, or have had read to me, this consent to treatment, understand the possible side effects and benefits of acupuncture and other procedures, and 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.

_____ _____
Signature of Patient or Guardian Date

_____
Print name of Patient or Guardian