**Informed Consent**

I hereby request and consent to the performance of acupuncture and other treatments within the scope of practice of an acupuncturist to be performed by Robin Arnold, AP (FL), L.Ac. (VA), on me (or on the patient named below if a minor, or for whom I am legally responsible), and or other licensed acupuncturists who now, or in the future treat me while associated with or serving as back-up acupuncturist to Robin Arnold, L.Ac.

I understand that there are minor risks associated with acupuncture treatment, including, but not limited to, slight bleeding and/or bruising of the skin, hematoma, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that the risk of infection is negligible when using single use, disposable needles. 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 Oriental Medicine. Some herbs and acupuncture treatments are contraindicated during pregnancy. I will notify the clinic practitioners if I am or intend to become pregnant.

I have had the opportunity to discuss with the acupuncturist the nature and purpose of acupuncture. I understand that results are not guaranteed.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications. I wish to rely on the acupuncturist to exercise good judgment during the course of the procedure, based on the facts they know, and act in my best interest. I will keep the practitioners informed of my current medications, medical conditions, and understand that I am responsible for obtaining appropriate primary medical care, which is not provided by this clinic.

I have read the above consent, or have had it read to me. I have had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend for this consent form to cover the entire course of treatment for my present condition, as well as any future conditions for which I may seek treatment.

I understand that any services, consultation, advice, products or treatments that I receive from the acupuncturist are not a substitute or replacement for conventional western medical services or treatment. I currently have a relationship with a state licensed medical doctor (M.D. or D.O.), and understand I am to continue my Traditional Medical care.

Following your treatment: (1) occasionally, a person may feel light-headed after an acupuncture treatment. If this happens to you, please sit for a while in the designated area. (2) Herbs or supplements recommended for the patient are intended for his or her use only, and should not be used by anyone other than patient.

Financial policy: I understand that I am expected to pay for services at the time of treatment, and that this clinic does not bill insurance, but will provide me with a receipt to submit for reimbursement (if applicable) upon request.

Please sign and date below to indicate that you have read and understand this form.

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Patient Signature Printed Name Date

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Patient Representative (include relationship, or if minor) Printed Name Date

Robin Arnold, MS, Dipl.Ac.(NCCAOM®);FL Lic AP 3450; Virg. L.Ac. Lic 0121001094