RIVER CLINIC
ORIENTAL MEDICINE

INFORMED CONSENT FORM

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I,_____, am seeking services from Poney Chiang, Practitioner of Traditional Oriental Medicine for services which may include acupuncture, herbal medicine, bodywork, energy-work, dietary therapy etc. I further understand that there are minor risks associated with acupuncture and that they include the potential for bleeding, bruising, irritation, numbness and tenderness at the site of needling. In addition I understand that on extremely rare occasions infections may occur. _____**(initial here)**

In connection with the services I am seeking, I consent to the use of other modalities such as gua sha (skin scraping), cupping, vapour steaming, herbal masks, topical herbs, venipuncture, moxibustion and electrical stimulation, that the practitioner in his professional judgement deems appropriate. I understand that some of these modalities may cause bruising, bleeding, pigmentation, blistering, irritation and allergic reactions on the skin. _____**(initial here)**

In the event that herbal therapy is recommended, I understand that allergic reactions or side-effects of the herbal therapy may occur on very rare occasions and it is my responsibility to inform my practitioner. I understand that I am responsible for payment for the cost of such herbs and that it is my responsibility to pick up herbal orders that are placed with River Clinic's dispensary on my behalf. In the event that I do not pick up these herbs, I am nonetheless responsible for payment for their costs. _____**(initial here)**

I understand that the nature of the services provided may be altered in the event of pregnancy as some procedures may be harmful under such circumstances. Accordingly, I agree to advise my practitioner if I am pregnant or planning on becoming pregnant and understand that this is a continuing obligation. _____**(initial here for female patient)**.

I hereby release Poney Chiang from any and all liability, which may occur in connection with treatment and the above-mentioned procedures. I understand that I am free to withdraw this consent and discontinue my participation in these procedures or treatment at any time.

By voluntarily signing below I show that I have read or have been read to me all the above information and risks to the above therapies. This consent covers the entire course of treatment for my current condition and any future condition(s) for which I seek treatment.

Patient's Name: _____ **Date:** _____

Phone Number: _____ **Email :**_____

Address:_____**Postal Code**:_____

Signature of Patient or Guardian: _____