INFORMED CONSENT TO ORIENTAL MEDICINE AND FUNCTIONAL MEDICINE HEALTH CARE

I hereby consent to the performance of Oriental Medicine and Functional Medicine upon myself (or the patient named below, for whom I am legally responsible) by Dr. Steven L. Benedict, L.Ac., O.M.D. (Licensed Acupuncturist and Doctor of Oriental Medicine) and/or his assistants, consisting of diagnostic techniques such as a review and discussion of my written intake questionnaire and other questionnaires, physical examination, pulse and tongue evaluation, palpation on a variety of areas of my body, and muscle and orthopedic testing. In addition, I consent to receive treatment, which may include any of the following modalities: acupuncture, acupressure, physical therapy, stretching, massage, electrical stimulation, moxibustion, cupping, heat/cold application, Chinese herbal medicine, homeopathy, nutritional counseling, dietary counseling and lifestyle counseling. I also understand that I may be recommended lab tests to provide additional diagnostic information relative to my chief complaints.

I understand that treatment with acupuncture is generally safe, but may cause possible side effects such as bruising, numbness or tingling near the needling sites, and dizziness or fainting. Extremely rare side effects can include infection, spontaneous miscarriage, organ puncture and nerve damage. (Note: only sterile, single use, disposable needles are used in this office.)

I understand that treatment with traditional Chinese herbs and/or high-grade nutritional supplements ("Nutraceuticals") is generally safe, but may cause possible side effects such as nausea, gas, bloating, headache or diarrhea. Some products may be inappropriate if trying to conceive or while pregnant.
I agree to notify the office if this situation applies to me.

I understand that Oriental Medicine and Functional Medicine have helped millions of people, but that specific guarantees for my individual results cannot be made.

I understand that Dr. Benedict is a Licensed Acupuncturist and Doctor of Oriental Medicine and is not an Allopathic Medical Doctor ("M.D."). He does not prescribe pharmaceutical medications and does not replace my medical doctor. I understand that it is my responsibility to consult my medical doctor for all of my medical conditions.

By signing below, I acknowledge that I have read and understand the above, and I consent to the above-mentioned procedures. I intend for this consent to cover treatment for my present condition(s) and any future condition(s) for which I seek treatment.

Date ___________________

Patient's Name ____________________________ Patient's Signature ___________________________

Parent/Guardian's Signature __________________________ Relationship to Patient _______________