MERIDIAN MEDICAL GROUP

Affiliate of the Institute of East-West Medicine

Case No. ______

INFORMED CONSENT

I, the undersigned, do hereby give my voluntary consent for the administration to me of medical treatment by the method known as acupuncture. This technique is to be applied by, or under the direction and supervision of, Dr. ______________________________.

Acupuncture has been explained to me as a medical treatment performed by the insertion of special needles (with or without the application of small pulses of electric current to the needles) through the skin into the underlying tissues, at certain indicated points on the surface of the body, for the purpose of the alleviation of pain or treatment of bodily diseases for an undetermined time. Alternate methods include other medical and/or surgical treatments.

I have been made aware of the possibility of complications which may result from this procedure. These include: infection, nerve damage, bruising or bleeding into the tissues, pain and discomfort, weakness, fainting, nausea, areas of anesthesia, needle breakage and /or retention, and even aggravation of symptoms existing prior to acupuncture treatment.

I am aware that the use of acupuncture, to which I am consenting, is not a common practice in this community. I accept the fact that there is no guarantee through the use of acupuncture. I am aware that I may withdraw this consent and stop acupuncture treatment at any time.

I hereby certify that I understand the above authorization and the risks of possible complications. I knowingly waive and decline any further information. All questions which I have asked have been answered by Dr.(s) Chang, Chen, and/or Zhang.

I hereby give my consent to the submission of any data arising out of, or in relation to my acupuncture therapy, to the New York State Department of Education and to any scientific organization for the purpose of evaluating the efficacy of this treatment in my condition.

dated: ______________

______________________________ ______________________________

patient signature or authorized agent witness