Fay Meling von Moltke Pao, R.TCMP, R.Ac, B.HSc, Hon.BA.

Practitioner of Traditional Chinese Medicine

Consent to Treatment Form

1. By signing below, I do hereby voluntarily consent to be treated with acupuncture and / or substances from the Oriental Materia Medica by a licensed acupuncturist in my own home or at the clinic of Fay Meling von Moltke Pao, R.TCMP, R.Ac, B.HSc, Hon.BA
2. I understand that acupuncturists practicing are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.
3. I understand that I must inform the practitioner if I am **pregnant**, suffer from a **communicable disease**, or have a **bleeding disorder**.
4. I understand that an acupuncture treatment involves the penetration of skin by sterile one-time use disposable filiform needles. Additional methods of treatment such as the use of electrical stimulation of needles, Tuina massage, cupping, moxibustion, Chinese herbal medicine, and application of heat may be used during the treatment. I understand that I am free to refuse any of these methods of treatment at any time.
5. I understand that certain adverse effects may result. These could include, but are not limited to: temporary light headedness, drowsiness, light tingling, soreness or slight bruising, minor bleeding and symptoms existing prior to treatment may temporarily worsen before improving.
6. I understand that no guarantees have been made to me as to the results that may be obtained from treatment. Chinese medicine treatment does not usually provide an instant relief for most serious or chronic ailments. Repeated treatments along with some lifestyle and dietary changes may be necessary for noticeable changes to take place.
7. I am aware that the fees for acupuncture treatments are not covered by OHIP. It is my responsibility to check with any company providing me with private health insurance for any applicable reimbursement to me for the cost of the acupuncture treatments.
8. I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for more detailed information. By signing this from, I give my consent to treatment.

Signature:_____ Date:_____

Printed name: _____ Date of Birth: _____

Address: _____

City:_____Province: _____Postal Code _____Phone: _____

Office Use Only:

I have answered the questions that the patient had regarding this Consent and have ascertained that he/she fully understands its content.

Practitioner Signature: _____Date:_____