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**Informed Consent Form**

I hereby voluntarily consent to be treated, and/or give my child to be treated with acupuncture and other treatment methods based on principles of Chinese Medicine, such as cupping, moxibustion, exercise therapy, Tui Na, herbs and other methods. I understand I may be given some dietary/nutritional, lifestyle advice and herbal supplementation and it is my decision whether or not to follow these recommendations. I understand that prior to treatment, these procedures including their risks have been explained to me. I understand there is no guarantee of success concerning the use and effects of these treatments and no such guarantee have been made by the Chinese Medicine practitioner. I understand that I may discontinue the treatment at any time and will inform my Chinese Medicine practitioner of this decision.

**Potential Side Effects and Reactions**

I understand that these treatments may result in some side effects or reactions including local bruising, minor bleeding, fainting, temporary pain or discomfort, and potential temporary aggravation of existing symptoms. Some rare risks associated with acupuncture include nerve damage, organ puncture and infection. This is minimised with the use of sterilised pre-packaged, disposable needles and sterilised equipment in accordance with national Infection Control Guidelines. I have read this page and have discussed any questions I have with my Chinese Medicine practitioner and understand the possible risks involved.

**Medical Referral**

I understand that under suitable circumstances, I should seek professional medical evaluation and treatment from a registered GP or qualified Specialist as acupuncture is not a substitute for proper medical diagnosis or treatment. I have been advised that if there is a worsening of my condition(s), or if there has not been any improvement within the timeframe discussed and agreed upon with the Chinese Medicine practitioner, I may be referred to further consultation with a GP or another allied health professional. If I am under the medical care of other doctors, I have been advised to continue all medications and treatments as prescribed until such time as my doctor/prescriber deems it appropriate to reduce, change or cease any medications or treatments.

**Cancellation Policy**

I understand the need to respect the time allotted for my treatment and that of other patients. Under circumstances where I wish to cancel my booking, I understand that I need to give at least 24 hours’ notice prior to my scheduled appointment or a 50% cancellation fee will be charged. However, I may reschedule my booking to another more suitable time within 24 hours of the scheduled appointment without cancellation charges.

I have read the above information and agree to be treated under the professional training and advice of my Chinese Medicine practitioner.

**\*\*Please sign over the page\*\***

PATIENT PRINTED NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Or patient representative)

**PATIENT CONFIDENTIALITY**

We will not disclose your personal information to any third party unless you have consented to such disclosure or where we are required to do so by law. If we are under a duty to disclose or share your personal data in order to comply with any legal obligation, we may disclose your information to a relevant authority. Any disclosure of personal information will be strictly controlled and made fully in accordance with current Australian law.