Dr. Kent Farnsworth, Dr.TCM, R.Ac.
Total Health Clinic 250-374-9700

Patient Information and Consent Form *Please read this carefully.*
Acupuncture, and other treatments provided by this clinic have proven to be highly effective in correcting conditions and maintaining overall wellbeing. Practitioners are required to advise patients that there may be some possible risks and complications that could arise with each individual case. You should be aware that the following side effects can occur

What are the possible side effects of acupuncture?

Drowsiness can occur in a small number of patients, if affected, you are advised not to drive.
Minor bleeding or bruising can occur from acupuncture and cupping.
Symptoms may become worse before they improve for 1-2 days following treatment. This is usually a good sign. Please advise your acupuncturist if worsening of symptoms continues for more than 2 days.
Fainting can occur in certain patients.

What are the possible side effects of Chinese Medicine and other treatments provided at this clinic?

The herbs and nutritional supplements that have been recommended are traditionally considered safe.

Is there anything your practitioner needs to know?

If you have ever fainted.
If you have a pacemaker or any other electrical implants.
If you are pregnant.
If you have a bleeding disorder.
If you are taking anti-coagulants (blood thinners) or any other medication.
If you have damaged heart valves or have any other particular risk of infection.

Statement of Consent
I confirm that I have read and understood the above information, and I consent to having treatments and procedures from this clinic. I have read the possible risks of treatment outlined above, but do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. I also understand that I can refuse treatment at any time. I wish to rely on my practitioner to exercise judgment during the course of treatment which, based upon the facts then known, is in my best interests. I understand the practitioner may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.
By voluntarily signing below I show that I have read this consent to treatment, have been told about the risks and benefits of treatments provided by this clinic, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present and future conditions for which I seek treatment.

Privacy Policy
The information received and collected about our clients/patients from their visits to The Total Health Clinic is strictly private and confidential. It is used and viewed only by the healthcare professionals and staff employed by The Total Health Clinic. The Total Health Clinic will not give, share, sell, or transfer any personal information to a third party unless required by law. Under absolutely no circumstances would this communication happen without the signed consent of the client/patient.

_____
Print name in full

_____
(Print name of representative if represented by another)

_____
Signature (Signature of Representative)

_____
Date