



AcupunctChi Clinic

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CONSENT FOR OFFICE PROCEDURE

Patient name: _____ D.O.B. _____

Patient address: _____

Home phone #: _____ Work phone#: _____ E-mail: _____

I, _____, authorize the performance upon _____

_____ of the following procedure _____

_____ for the diagnosis of: _____

Under the direction of: _____ at _____

For the purpose of: _____

I acknowledge that the proposed procedure, the potential risks and benefits, and the possible complications of such procedure have been explained to me as well as the possible risks and benefits of not undergoing this procedure. I further acknowledge that alternative methods of available treatment were discussed with me, and that I was given adequate opportunity to ask questions pertaining to this procedure and the alternative methods. No guarantee or assurance has been given by anyone as to the results that may be obtained from this procedure.

Signature of Patient or Guardian

Date

Relationship to patient

Age of Person Consenting

Signature of Informant

Date