Dr. Debbie Lee, Registered Doctor of TCM, Acupuncturist & Herbalist
Suite 203, 1750 East 10th Avenue
Vancouver, BC V5N 5K4

INFORMED CONSENT TO ACUPUNCTURE & CHINESE HERBAL MEDICINE TREATMENT & CARE

I, the undersigned, hereby request and consent to the performance of acupuncture procedures including, but not limited to moxibustion, cupping, plum blossom, gua sha, electroacupuncture, herbology, and tuina, on me (or on the patient named below for whom I am legally responsible) by my practitioner, Dr. Debbie Lee, Registered Doctor of Traditional Chinese Medicine.

Potential risks: discomfort, pain, fainting, nausea, temporary discoloration at site of procedure, infection, weakness, bruising
Potential benefits: drugless relief of presenting symptoms and improved balance of body's energies, which may lead to prevention or elimination of the presenting problem.

I have had the opportunity to discuss with the acupuncturist named above and/or with other office or clinic personnel the nature and purpose of acupuncture, moxibustion, cupping, electroacupuncture, herbology, and other procedures. I understand that there are no guarantees regarding cure or improvement of my condition. I understand and am informed that there are some risks to acupuncture and Chinese medicine, such as those listed above. I understand that some herbs may be inappropriate during pregnancy. If I suspect that I am pregnant, I will immediately inform the practitioner. If I experience any gastro-intestinal upset or allergic reactions to the herbs, I will inform the practitioner.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I hereby release Dr. Debbie Lee, Registered Doctor of Traditional Chinese Medicine from all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and discontinue participation at any time.

CANCELLATION POLICY:

I am fully aware that the clinic allots a specific amount of time for my treatment, and that if I arrive late, my treatment will be adjusted to fit into that schedule. I also understand that except in emergencies, I must give **48 hours notice** of intent to cancel or reschedule my appointment. Late arrivals and appointments missed without proper notice will be billed at the current rates.

______________________________	______________________________
Signature of patient or person authorized to consent	Date
______________________________	______________________________
Print name of patient or patient's representative	Relationship of representative