Trina Lion, L.Ac.
Informed Consent Form

Today's Date _____
Name (please print) _____
Mailing Address _____
Email Address _____ Phone _____ (Daytime) _____ (Evening)

I hereby request and consent to the treatment of Traditional Chinese Medicine (TCM) within the scope of Trina Lion, L.Ac. on myself (or, if the patient is a minor, on the patient named below, for whom I am legally responsible). The forms of treatment may include acupuncture, acupressure; manual therapies such as Gua Sha, cupping, moxibustion; and TCM dietary theory. I understand that the results are not guaranteed. I understand that treatment by Trina Lion is not a replacement for treatment by a licensed physician, by my primary health care provider, or my personal responsibility for my own health and healing. During the course of treatment, I will notify Trina Lion in the event of any change in my health, medication usage or pregnancy status. If I have a bleeding disorder or pacemaker, I will notify Trina Lion before treatment.

I understand that acupuncture involves the insertion of pre-sterilized, disposable needles beneath the surface of the skin into anatomical areas for specific clinical functions. I understand that acupuncture can lead to side effects, including, but not limited to, skin irritation or temporary skin color change (redness or itchy skin at the site of needle insertion), numbness or tingling near the area of the procedure, slight bleeding, or skin bruises. It is also possible to experience light-headedness, fatigue, or nausea. Although it is rare, acupuncture can also result in broken needles, fainting, infection, spontaneous miscarriage, nerve damage and organ puncture.

I do not expect Trina Lion to be able to anticipate and explain all possible risks and complications. I expect that she will use good judgment during the course of the procedure, based on the facts then known, and that she will act in my best interest. I understand that treatment by Trina Lion is not a substitute for medical treatment by a licensed physician. If my condition worsens, does not improve within the time frame proposed at the beginning of a treatment, or if a new condition arises, I should consult a licensed physician. If I experience a medical emergency, I will consult a physician or hospital.

I understand that treatment fees are based on a sliding scale of between $40 and $60, based on my income level, no proof of which is required at the time of treatment. I understand that payment will be required at the time of service. In the event I need to cancel or change my appointment in less than 24 hours, I will be responsible for the treatment fee. I understand that treatments are 20 minutes in length. In the event that I request a longer treatment, I will be subject to the hourly rate of $120.

I have read the above consent, or I have had it read to me. I have had an opportunity to ask questions about its content, and by signing below I understand the named procedures and potential outcomes. I permit a copy of this authorization form to be used in place of the original. I intend for this consent form to cover the entire course of treatment for my present condition, as well as any future concerns for which I seek treatment.

Patient Signature _____ Date _____
(or guardian, if the patient is a minor)

Traditional Chinese Medicine Specialist with Ten Years Experience in China
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