Informed Consent for CommuniChi
Community Acupuncture Clinic

In accordance with WAC 246-82-120, I bring the following to your attention:

1. Practitioner's Qualifications:

Jordan Van Voast, L.Ac. Northwest Institute of Acupuncture, MA Acupuncture, 1997. WA DOH, license #AC00000432.

2. Scope of Practice: The scope of practice for an acupuncturist in the state of Washington includes but is not limited to, use of acupuncture needles to stimulate acupuncture points and meridians, dietary advice based on traditional Chinese medical theory.

3. Side effects may include pain following treatment in insertion area [uncommon], minor bruising [uncommon], infection [rare], fainting [rare], drugless relief of condition, enhanced well being, physical immunity, increased mental clarity and insight [common]

4. Patients with severe bleeding disorders or pace makers should inform practitioner prior to any treatment.

5. Please turn off your cell phone before entering the treatment area. Thank You.

In accordance with WAC 246-802-110: If you are affected by any of the following conditions, we are required to request that you consult with a physician and provide a written diagnosis from him/her, or have the physician call us: Cardiac conditions including uncontrolled hypertension, Acute abdominal symptoms, Acute undiagnosed, neurological changes, Unexplained weight loss or gain in excess of fifteen percent body weight within a three month period, Suspected fracture or dislocation; Suspected systemic infection; Any serious undiagnosed hemorrhagic (bleeding) disorder; and Acute respiratory distress without previous history or diagnosis. *Please inform us if you are pregnant. *To reduce the possibility of infection, all needles are pre-sterilized, one-time-use-only, made of surgical stainless steel.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by CommuniChi regarding cure or improvement of my condition. I hereby release CommuniChi from any and 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 this consent and to discontinue participation in these procedures at any time.

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Name (Please print)

_____ _____

Signature date