*Annapolis Family Acupuncture*
*Dr. Molly Harbour Hutto, L.Ac, DACM, Dipl. OM*

# Informed Consent for Oriental Medical Treatment

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of Oriental Medicine on me (or on the patient named below, for whom I am legally responsible) by Dr. Molly Harbour Hutto, and/or other practitioners of Oriental Medicine who now or in the future treat me while employed by, working or associated with or serving as back-up for Dr. Molly Harbour Hutto, whether signatories to this form or not.

I understand that there may be limitations to the care provided and that in my best interest, I may be referred to another Oriental Medical practitioner or other healthcare provider who may be more qualified to treat me outside of the practice of Dr. Molly Harbour Hutto.

I understand that although they are very minor, there are some risks to treatment, including but not limited to some bruising of the skin and/or slight bleeding. If moxibustion or heat therapies are used there is a risk of burn or scarring. The risk of infection is small when all needles are sterile. I understand that *only* disposable needles (which are sterile) are used in this facility.

I have had an opportunity to discuss with Dr. Molly Harbour Hutto the nature and purpose of Oriental Medicine. I understand that results are not guaranteed.

I do not expect the practitioner to be able to anticipate and explain all risks and complications. I wish to rely on the practitioner to exercise judgement which she feels at the time is in my best interest, based upon the facts then known, during the course of the procedure.

I understand that I have the choice to accept or reject the proposed diagnostic procedure or treatment, or any part of it, before or during the diagnosis or treatment.

I understand that Dr. Molly Harbour Hutto is not providing Western (allopathic) medical care, and that I should look to my Western primary care practitioner (i.e. MD) for those services and for routine check-ups.

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.

***The practitioner has discussed the above information with me; all proposed procedures have been described to me, and I understand this information.***

**Patient Signature _____ Date _____**

**If signed by representative, state relationship to patient: _____**

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**I have discussed the above information with the patient, including the risks, benefits, and alternatives to the proposed treatment.**

**Practitioner Signature/Date _____**