

INFORMED CONSENT TO TCM TREATMENT AND CARE

1. Patient:

- (a) Name: _____
(b) NRIC / Fin No.: _____
(c) Mobile No: _____

2. Next of Kin* / Guardian* (delete where applicable):

- (a) Name: _____
(b) NRIC / Fin No.: _____
(c) Relationship with Patient: _____

I hereby request and consent to the performance of procedures on me which are within the scope of practice of Chinese Medicine including, but not limited to, history-taking, acupuncture, electro acupuncture, indirect moxibustion, warm needle moxibustion, Tui-na and cupping, and medication prescriptions, by **Dr Clement Ng Shin Kiat**, a licensed TCM Practitioner.

I have had an opportunity to discuss with TCM Practitioner the nature and purpose of acupuncture and treatment. I understand that results are not guaranteed.

I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, bruising, tingling or soreness near the needling sites that may last a few days. There have been instances reported of fainting, infections and scarring. I will notify the TCM Practitioner if I take steroids or anti-coagulants or if I have an implanted pacemaker or a prosthetic heart valve. If I experience any gastrointestinal upset or apparent allergic reactions to an herbal prescription, I will stop taking the herbs and inform the TCM Practitioner.

I do not expect the TCM Practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on the TCM Practitioner to exercise judgment during the course of the treatments, based upon the facts then known.

I understand that all personal information collected during the course of treatment is solely used for the purpose of providing the service.

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.

Signature of Patient* / Next of Kin* / Guardian*

Date

*Next of Kin's details and signature are mandatory for patient below 21 years of age.

Signature of TCM Practitioner

Date