Patient Informed Consent to Treatment

TG Wellness Clinic
1420 Burnhamthorpe Road East Mississauga Tel: 9056290820

I, _____
[name of patient or the substitute decision-maker (SDM) listed below]

consent to have __XiaoHua Guo, Chengjin Li , Lin Zhao_____
[name of practitioner]

perform the following treatment* on me:

acupuncture treatments and other procedures such as cupping, Guasha and moxibustion if it is needed for my condition within the scope of the practice and Herb tea prescription.

*If treatment includes sensitive areas, I, consent to have _XiaoHua Guo, Chengjin Li, Lin Zhao,
[name of practitioner]

provide assessment and/or treatment of the areas indicated below:
[please check the appropriate box(es)]

- ☐ Upper and inner thigh
- ☐ Buttocks
- ☐ Penis
- ☐ Vagina
- ☐ Breasts
- ☐ Chest wall muscles

I acknowledge that XiaoHua Guo, Chengjin Li, Lin Zhao_____
[name of practitioner]
has explained the following to me:

- the nature of the treatment, as set out above
- if applicable, the clinical reason(s) for the assessment of the above sensitive area(s) and the draping methods to be used the expected benefits of the treatment
- the material risks of the treatment
- the material side effects of the treatment
- the alternatives to having the treatment
- the likely consequences of not having the treatment

I acknowledge that my practitioner cannot guarantee the results of the proposed treatment.

I acknowledge that I have informed my practitioner about my relevant health history, including whether I have any allergies, metal implants, if I suffer from any type of major bleeding disorder, if I use a pacemaker, or if I have any infectious viruses or diseases.

I understand that my consent is voluntary, and I have the right to withdraw my consent to the treatment at any time.

I understand that the fees charged for my treatment are not covered under OHIP and must be covered in full by myself or through third party insurance. I am responsible for the full and

prompt payment after services have been rendered. I acknowledge that my practitioner has explained the applicable fees to me.

I acknowledge that I have discussed the content of this form with my practitioner. I acknowledge that I have asked any questions I may have and received answers I understand.

By signing this form, I give my informed consent for the treatment set out above.

Signature of Patient/SDM: _____ **Date** _____

By signing this form, I acknowledge that I have reviewed the form with the patient (or substitute decision-maker) and have answered the patient's (or substitute decision-maker's) questions.

Practitioner's Signature: _____ **Date:** _____