EAST BY SOUTHWEST, ROBYN BENSON, D.O.M.

INFORMED CONSENT TO HEALTH CARE BY A DOCTOR OF ORIENTAL MEDICINE

I hereby request and consent to the performance of the following on me (or on the patient named below, for whom I am legally responsible) by Robyn Benson, D.O.M. and/or other licensed doctors 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. Robyn Benson, including those working at this clinic or any other associated clinic: acupuncture and other oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, manual palpation on a variety of areas of my body, observation, range of motion evaluation, muscle, orthopedic and nuerologic testing; modes of manual or physical therapy such as massage, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation; injection and IV therapy; oxidative therapys: the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendations; advise regarding exercise regimens; and lifestyle counseling.

I have had an opportunity to discuss with Dr. Robyn Benson and/or with other clinic personnel the nature and purpose of acupuncture and oriental medical procedures. I understand that although acupuncture and other oriental medical procedures have helped millions of people, no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of allopathic medicine, in the practice of oriental medicine there are some risks to treatment. I understand that while unlikely, possible risks include but are not limited to: bleeding, bruising, pneumothorax (puncture of the lung), puncture of other organs, pain or other strong sensations at the location where a needle is inserted or radiating from that location, nerve pain, burns, aggravastion of current symptoms, appearance of new symptoms, general aches, sprains, strains, dislocations, fractures, disc injuries and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications, and during the course of treatment I wish to rely on the doctor's judgement based on the facts known at the time.

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 following is to be completed by the patient or by the patient's representative, if necessary, e.g.; if the patient is a minor or physically or legally incapacitated.

Print Name of Patient	Print Name of Patient's Representative
Signature of Patient	Signature of Patient's Representative
Date Signed	Relationship of Patient's Representative

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