St. John's Hospital

ST. JOHN'S HOSPITAL
800 E. Carpenter St.
Springfield, Illinois 62769

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I, _____, consent to my participation in the St. John's Hospital
*(print name)*

Acupuncture Therapy Program. I understand that acupuncture is part of Traditional Chinese Medicine which includes: Oriental medical diagnosis, acupuncture (needle insertion), electrical or mechanical stimulation of acupuncture points or meridians, dietary and exercise advice for the purpose of creating balance and treating illness. I am aware of both the benefits and risks of acupuncture (bruising, infection) and give my consent for treatment. I have stated all medical conditions that I am aware of and will update my practitioner of any changes in my health status.

I understand that the acupuncture is being provided by an acupuncturist licensed by the State of Illinois. I understand that the practice of medicine in general, and the practice of Traditional Chinese Medicine are not exact sciences. I further acknowledge that no guarantees have been made to me as to the results of such treatment.

I understand that physicians providing my care including my treating physician, SIU residents, hospital based physicians, radiologists, pathologists, anesthesiologists, neonatologists, and Emergency Department physicians are not employees or agents of the hospital, but rather are independent contractors who have been granted the privilege of using its facilities for the care and treatment of patients.

I acknowledge that I have read this document in its entirety and that I fully understand it.

_____ Date

_____ Time

_____ Signature of patient or legal guardian

_____ Relationship

_____ Witness #1

## ACUPUNCTURE THERAPY CONSENT



An Affiliate of Hospital Sisters Health System