INFORMED CONSENT FORM

I hereby authorize and consent to my participation in a clinical research study on the health care efficacy of auriculotherapy, auricular acupuncture, and ear reflexology. I am aware that these health care treatments involve stimulation of reflex points on the external ear in order to alleviate health disorders in other parts of the body.

I understand that this study is concerned with the systematic assessment of treatment outcome measures obtained before and after the clinical application of auriculotherapy. I understand that there will be several treatment sessions, offered one to two times a week, for up to ten weeks. I know that I can request additional treatments as needed after that time. I understand that auriculotherapy treatment may sometimes include the insertion of needles into acupuncture points on the body and the external ear or the use electrical stimulation of the skin over ear reflex points.

I understand that my participation will involve completing several surveys of health distress, pain intensity, and questionnaires on my demographic background and health history. I have been informed that it will take approximately 30 minutes to complete these surveys on the first treatment session, up to ten minutes to fill out forms on subsequent sessions, and then another 20 minutes for questionnaires at the end of the final session. I have been further informed that an investigator will assess muscle tenderness to applied pressure on my body and limitations to my range of motion. I also understand that I will be asked to complete a daily diary, which will require approximately 5 minutes a day, for each day of the four to five weeks I am receiving treatment.

I understand that I am not required to fill in a response to any question that I do not feel comfortable answering. I further understand that I have been asked to not engage in any other health care procedures during this two to ten week period, except for the auriculotherapy and the medical procedures I am already engaged in. I understand that I can request to change the dose or type of any medications that I am taking after first consulting with my doctor. If I or my doctors believe that some new medication or procedure is necessary, I know that I am free to make such changes under informed medical advice.

I understand that an identification number will link my answers to the consent forms and health distress surveys that I complete. I understand that all forms and surveys will be kept confidential and that the data will be used for research purposes only.

I fully understand that I am free to withdraw from participation in this study at any time during my participation, and that I am not obligated to complete the surveys and questionnaires.

I understand that there are no anticipated risks or discomforts involved in my participating in this study and that I will receive no direct benefit from participating. However, the published findings of this study may be helpful to health care practitioners desiring to better understand auriculotherapy, auricular acupuncture, and auricular medicine, and how they can benefit patient healing.

My signature indicates that I have read and understand this consent form and that I agree to participate in the study.

Participant's Name (Print): _____ Date: _____

Participant's Signature: _____