

Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture, alternative medicine, herbs and other substances by a licensed acupuncturist in this clinic.

Acupuncture: I understand that acupuncture is performed by the insertion of needles through the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, numbness, minor bleeding, fainting, pain or discomfort and the possible aggravation of symptoms existing prior to acupuncture treatment. Other unusual but rare risks include lung or organ puncture, nerve damage, and spontaneous miscarriage. I understand that no guarantees concerning its use and effects are given to me and that I may stop acupuncture treatment at any time.

Moxibustion: I understand that if I receive moxibustion (heat therapy) as part of therapy, there is a risk of burning. With the use of direct moxibustion burning and/or scarring may result from its use. I understand that I may refuse either of these therapies.

Cupping and Gwa-Sha: I understand that if I receive cupping or gwa-sha (scraping) as part of therapy, there is a risk of tenderness, redness, bruising and blistering. I understand that I may refuse this therapy.

Chinese Herbs & Supplements: I understand that herbs and supplements may be recommended to me to treat bodily dysfunctions, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movements, abdominal pain/discomfort, nausea/vomiting, rashes and possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems which I associate with these substances, I will suspend taking them and call my acupuncturist as soon as possible.

Acupressure/Tui Na/Massage: I understand that I may also be given acupressure/tui na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

Acupoint Injection Therapy: I understand acupoint injection therapy involves the injection of herbs, homeopathics and other nutritional supplements in the form of sterile supplements into acupuncture points by means of hypodermic needles. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: pain, mild bleeding, redness, swelling or numbness around injection site, muscle stiffness, fatigue, diarrhea, mild to severe allergic reactions, and possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this therapy.

Nutritional and Lifestyle Counseling: I understand that the practitioner neither claims nor implies that any instruction, advice, recommendations, services, or herbal/nutritional products the practitioner provides or recommends will cure, treat, prevent or mitigate any disease condition, but are provided solely for the purpose of nourishing and strengthening the natural function of the various body organs and systems so that they may have a greater capacity to heal themselves. I understand that the practitioner believes many diseases are related to unresolved emotional conflicts. I understand that counseling or assistance offered in this area is done on a spiritual basis and does not replace licensed psychiatric care or professional counseling. I request the advice and assistance of this practitioner in helping me to learn what I can do to improve my health and fitness. I request this information and any products or services that may attend it as my right to Freedom of Choice in Medicine and Health care retained by me under the Ninth Amendment to the U.S. Constitution, of certain rights, shall not be construed to deny or disparage others retained by this person.

I understand that the acupuncture practitioner must be advised if I have a pacemaker, cardiac condition, bleeding disorder, history of seizures, on blood thinners (Coumadin, Warfarin, etc.), or if I am or may be pregnant.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

If I have not already done so, I agree to consult with a medical doctor for any serious or life-threatening disease or condition either for myself or those under my guardianship.

I have carefully read and understand all information contained within this consent to treatment form and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

SIGN BELOW ONLY IF YOU REQUESTED AND RECEIVED MORE DETAILED INFORMATION

I requested and received, in substantial detail, further explanation of the procedure or treatment other-alternative procedures or methods of treatment and information about the material risks of the procedure or treatment. I give my my permission and consent to treatment.

X
Patient Signature _____ Date _____

X
Explained by me and signed in my presence. _____ Date _____