CONSENT TO TREATMENT

By signing below, I, _____ , do hereby voluntarily consent to be treated with acupuncture, Chinese Herbs, and/or other Oriental Medicine procedures relevant to my diagnosis and treatment principle by a licensed acupuncturist at the Park Acupuncture and Herbal Medicine Clinic.

Acupuncture / Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) 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, although rare, certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

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.

Gua Sha: I understand that it is one of the massage techniques that leave redness on the skin that can last for 1-5 days. Slight bruising and tenderness may persist after the treatment.

Cupping: I understand that it may be used to promote circulation of Qi (energy) through the meridians. Cups may produce a red/purple color on the area treated lasting for 1-5 days.

Bloodletting: I understand that it alone, or in conjunction with cupping, may be used to improve circulation in specific meridians. Lancets are inserted into the skin and a small amount of blood is expressed from the puncture.

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.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, 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 effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call the Park Acupuncture and Herbal Medicinec as soon as possible.*

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

I have been informed that I have the right to refuse any form of treatment. I understand the nature of the treatment, have been informed of the risks and possible consequences involved with this treatment, and have given an opportunity to ask questions pertaining to the treatment. I also understand there is always a possibility of an unexpected complication. I give my permission and consent to treatment.

Patient Signature:_____.

Patient Name:_____ **Date:**_____.

Acupuncturist Name:_____.