Consent to Treatment

I, _____, hereby acknowledge that being treated with Traditional Chinese Medicine can include any of the following techniques:

1. Insertion of different sizes of acupuncture needles into my body at various depths and locations.

2. Heat treatments using Artemesia vulgaris (moxibustion) or a conventional heat lamp may be placed on or near any part of my body. For indirect moxabustion treatment the moxa is placed on the head of the needle or on top of a barrier (such as a slice of ginger or salt), which rests on the skin. When direct moxa is used a very tiny amount of moxa is placed on a protective cream on the skin. The heat generated from the moxa treatments may involve slight discomfort or leave a small blister or scar on the skin. With any type of heat there is always a risk of a burn.

3. A massage technique called gua sha may produce red or purple discoloration of the skin (similar to a bruise), which may remain for 1 to 7 days. There may also be a slight tenderness in the area treated.

4. A method called cupping involves placing glass cups over the skin to produce a vacuum and promote the circulation of qi and blood through the tissue. Cupping may also produce skin discoloration and tenderness 1 to 7 days after the treatment.

5. The practitioner may leave press-balls, press-tacks, press-seeds, interdermals, or magnets on my body. I will receive directions on how to care for and when to dispose of these adjuncts.

6. I may also receive herbal prescriptions or recommendations pertaining to nutrition, diet, exercise, or other life-style habits. I understand that I 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 clinic as soon as possible.

Consent to Treatment (cont.)

The patient or guardian will advise me if the patient has a pacemaker or a bleeding disorder, might be pregnant or has a contagious disease. If the patient has a potentially serious condition that is out of my scope of practice, the patient will be referred to the emergency room or to a medical doctor with regard but not limited to: cardiac conditions including uncontrolled hypertension; acute, severe abdominal pain; acute undiagnosed neurological changes; unexplained weight loss or gain in a three month period; suspected fracture or dislocation; suspected systemic infections; any serious undiagnosed hemorrhagic disorder; and acute respiratory distress without previous history.

I have been informed that I have the right to refuse any form of treatment and that I have the right to terminate our treatments at any time. I understand the nature of the treatment, have been informed of the risks and possible consequences involved with this treatment, and was given the opportunity to ask questions pertaining to my treatment. I also understand that there is always the possibility of unexpected complication and I understand that no guarantee can be made concerning the results of the treatment.

Available by appointment on Tuesday, Friday, and Saturday. A credit card is required to secure your appointment, and cancellations without a 24 hour notice will be assessed the full visitation fee.

I authorize payments and benefits be made directly to this provider and I understand that I am responsible for charges not covered by insurance benefits. I agree to pay the full visitation fee if I do not cancel at least 24 hours in advance.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I give my permission and consent to treatment.

_____

Your Signature (parent or guardian if minor)

_____ _____

Print your name (parent or guardian if minor & patient name) Date