Acupuncture Associates
Providing Happy Acupuncture

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Consent to Treatment Form

I do hereby voluntarily consent to be treated with acupuncture, Chinese medicinal herbs and Oriental medicine by a licensed acupuncturist at Acupuncture Associates. I understand that acupuncturists practicing in the state of North Carolina are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended.

Initial here_____ **Acupuncture/Moxibustion:** I understand that acupuncture is performed by the insertion of sterile single use needles through the skin or by the application of low intensity laser light on the skin or by the application of heat to 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. Acupuncture and Moxibustion are typically safe methods of treatment, however certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, dizziness, 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. *Parent / Guardian Initials:* _____

Initial here_____ **Pregnancy:** I will notify Acupuncture Associates should I become pregnant or if I am in the process of trying to become pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process. Acupuncture Associates is not liable for any adverse effects that may be caused to the patient while pregnant without Acupuncture Associates knowledge of pregnancy. *Parent / Guardian Initials:* _____

Initial here_____ **Direct Moxibustion:** I understand that if I receive direct moxibustion as part of therapy, there ***will likely be burning or scarring of the skin from its use.*** In fact, burning and scarring may even be a part of the therapeutic action, and may be intentional, on the part of the practitioner. I understand that I may refuse this therapy at any time for any reason. *Parent / Guardian Initials:* _____

Initial here_____ **Chinese Herbs:** I understand that Chinese medicinal herbs 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 effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, nausea & vomiting, 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 Acupuncture Associates as soon as possible.*** Acupuncture Associates is not responsible or held liable if Chinese herbs are improperly administered. *Parent / Guardian Initials:* _____

Initial here_____ **Acupressure/Tui-Na Massage, Qi Gong:** I understand that I may also be given acupressure/tui-na massage and/or Qi Gong 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 this treatment at any time for any reason. *Parent / Guardian Initials:* _____

Initial here_____ **Cupping / Gua Sha:** I understand that I may also be given cupping (the application of glass cups with vacuum to the skin) and Gua Sha (rubbing of the skin with a smooth object such as a porcelain spoon) as part of my treatment to modify or prevent pain perceptions and to normalize the body's physiological functions. ***I am aware that these treatments are intended to cause minor bruising and though unsightly are not normally painful***. However, 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 refuse the treatment or stop the treatment at anytime for any reason. *Parent / Guardian Initials:* _____

Initial here_____ **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 stop this treatment at any time for any reason. *Parent / Guardian Initials:* _____

Initial here_____ I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. *Parent / Guardian Initials:* _____

I do not expect Acupuncture Associates to be able to anticipate and explain all possible risks and complications of treatment. I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation of anything regarding my treatment. I understand that my records will be kept confidential and will not be released without my written consent (unless in an emergency or by legal demand). I give my permission and consent to treatment.

Signature: _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____

Parent / Guardian Signature: _____ **Parent / Guardian Name:** _____