



Disclaimer Consent to Treatment

I, _____, hereby authorize
to administer any style of Oriental Medicine relevant to my diagnosis
and treatment, including but not limited to the following:

1. Insertion of various styles and sizes of acupuncture needles into my body at various depths and locations.
2. Heat treatment using the (moxibustion, “moxa”) or a conventional heat lamp may be placed on or near any part of my body. For indirect moxibustion treatments, the moxa is placed on the head of the needle or barrier (such as a slice of ginger or salt) which rests on the skin. When direct moxa is used, the moxa is placed directly on the skin. The heat generated from moxa treatments may involve slight discomfort or leave a small blister or scar on the skin. With any type of heat, there is a risk of burn.
3. A massage technique called “gua sha” may produce redness on the skin which remains for 1-5 days. A slight bruising or tenderness may persist following the treatment.
4. Cupping may be used to promote the circulation of Qi (energy) through the meridians. Cups may produce a red/purple color on the area cupped which may remain for 1-5 days.
5. Electrical stimulation may be used which produces a vibration/tapping sensation on the needles. Ion pumping cords may be attached to the needles.
6. Patients prescribed herbs may be concerned individuals should consult with their primary care provider or pharmacist.

I have been informed that I have a 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 was given an opportunity to ask questions pertaining to my treatment. I also understand there is always a possibility of unexpected complications and I understand that no guarantee can be made concerning the results of the treatment.

The doctor and clinic expressly disclaim responsibility for any of the aforementioned conditions resulting from treatment. Your understanding and acknowledgement concerning this matter are appreciated.

Signature of Patient: _____

Printed Name: _____

Date: _____

Practitioner Signature: _____