

Good Health Acupuncture & Chinese Herbs, Inc. Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture, Oriental medical modalities and/or substances from the Oriental Materia Medica by practitioners at Good Health Acupuncture & Chinese Herbs, Inc. I understand that acupuncturists practicing in the state of Colorado are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

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 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.

Shonishin: I understand that shonishin is a set of tools that rub, lightly scrape, tap or roll over acupuncture points and channels. I am aware that certain adverse side effects may result. These could include, but are not limited to: 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/shonishin treatment at any time.

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

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 effects 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 Good Health Acupuncture & Chinese Herbs, Inc. as soon as possible.*

Acupressure/Tui-Na/Shiatsu Massage: I understand that I may also be given acupressure/tui-na/shiatsu 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.

Cupping/Guasha: I understand that I may also be given cupping/guasha 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.

Facial Rejuvenation Acupuncture: The patient is advised that a high chance of bruising of the face is possible. The patient also understands and agrees to the best of their knowledge that they are not diagnosed with any of the following: high blood pressure, heart disorder, pacemaker, pituitary disorder, cancer, bleeding or bruising problems, pregnancy, a bout with common cold or flu, current migraine headaches, an allergic attack, or an acute herpes outbreak.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I understand that utilizing the services of Good Health Acupuncture & Chinese Herbs, Inc. and participation in acupuncture and related treatments is strictly voluntary and that I may discontinue services with Good Health Acupuncture & Chinese Herbs, Inc. at any time.

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. I give my permission and consent to treatment.

Signature (patient or guardian): _____ **Date:** _____

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

Patient's Name (if under 18 years old) _____