CONSENT TO TREATMENT

Informed Consent to Receive Treatment:

By signing below, I do hereby request and voluntarily consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named above and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

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 recommended by this clinic's practitioners.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, nutritional counseling, QiGong as well as Telehealth (2-Way Video-Audio Conference) Sessions.

ADVERSE EVENTS and RISKS:

Acupuncture involves the insertion and stimulation of fine, sterile and single use needles through the skin. Acupuncture is considered a safe method of treatment. Treatments can occasionally produce a mild but temporary discomfort, achiness, tingling or soreness at the acupuncture site. Treatments can also cause slight bleeding and may occasionally leave a non-painful bruise at the acupuncture site. Other possible risks from acupuncture include dizziness and fainting.

I agree to come to each session having eaten within the past 3 hours, and I will report to my Licensed Acupuncturist any dizziness or light-headedness that occurs during or after an acupuncture treatment. Extremely rare risks of acupuncture include nerve damage, organ puncture, pneumothorax and infection. These risks have an extremely low incidence, especially when acupuncture is administered properly by a Licensed Acupuncturist.

CONTRAINDICATIONS:

Contraindications for acupuncture treatment and certain herbs may include a history of a bleeding disorder or current anticoagulant therapy, an implanted pacemaker or prosthetic heart valve, use of certain medications, or pregnancy. I will inform my practitioner if any of the above apply to me at any time. I will also inform my acupuncturist of any and all medications I am using.

TRADITIONAL CHINESE HERBAL MEDICINE: Chinese herbs have been used safely for centuries. Infrequently, one may experience digestive upset or other reactions to herbs such as rashes, hives and tingling of the tongue. If I experience any discomforts related to the use of any herbs I am prescribed, I understand that I should stop the herbs and that I am responsible for informing my Licensed Acupuncturist of my symptoms. Some herbs may be inappropriate during pregnancy or breastfeeding. I accept full responsibility to inform my practitioner immediately if I am pregnant or breastfeeding, or if I am attempting or suspecting pregnancy. With all herbal treatment, I agree to follow the prescribed dosage and administration guidelines given to me by my acupuncturist. I will inform my practitioner if I am taking any medications, or if there are any changes in my medications, before any herbal treatment is initiated.

HEAT TREATMENTS (Moxa or a TDP Lamp): These methods are used to warm areas of the body to promote health. Every precaution is taken to prevent over-warming, but the rare possibility of mild burns exists.

CUPPING: This technique involves a localized suction produced by a small glass cup. There is a possibility of local non-painful bruising from this suction.

GUA SHA: Gua Sha is light scraping on the skin in a small area using a smooth-edged instrument. This often results in bruising of the treated area. The bruising, which is not painful, usually resolves in 3-7 days.

ELECTRO-ACUPUNCTURE: A mild electric micro-current similar to a TENS treatment may be used to stimulate the acupuncture points. A mild tingling or tapping sensation will be felt during treatments. Occasionally a mild achiness or soreness will be felt at the areas treated for up to a day after the treatment. I understand that I must inform my practitioner if I am using a pace maker or have any heart or neurological condition prior to having this treatment.

ACUPRESSURE AND MASSAGE: Acupressure and massage are used to reduce or prevent pain, and to normalize the body’s physiological functions. I will inform my Licensed Acupuncturist of any areas of injury or extreme discomfort, as well as any areas where I have had surgery, prior to any massage. I understand that there may be muscle soreness or achiness as well as the possible aggravation of symptoms existing prior to the treatment during or after massage.

I understand the clinical and administrative staff may review my patient records and lab records but all my records will be kept confidential and will not be released without my written consent. By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend

this consent form to cover the entire course of treatment for my present conditions and for any future condition(s) for which I seek treatment.

Patients who are pregnant, have a pacemaker or heart condition, have a seizure disorder, or those with a bleeding disorder or taking blood thinners should discuss this with the acupuncturist before proceeding with acupuncture. I understand that there may be other treatment alternatives, including treatment offered by a licensed physician, as practitioners at Elevated Acupuncture, are not primary care physicians. By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

By signing below, I am agreeing to the above. I have also received and read the clinic's HIPAA policy.

Signature of patient:_____

Printed name of patient:_____

Date:_____

Signature of practitioner:_____