Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture by a licensed acupuncturist. I understand that acupuncturists practicing in the state of Massachusetts 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 sterile needles through the skin or by the application of heat to the skin (or both) at certain points. This is 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.

Acupressure/Cupping: I understand that I may also be given acupressure/cupping 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. 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.

Lancets may be used in micro-bleeding in order to express a small drop of blood from the puncture.

Nutritional advice based on TCM may be given to enhance the affects of the treatment and to empower the patient to participate in their own health care.

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, and that I have a right to refuse any form of treatment. I give my permission and consent to treatment.

_____

Patient's name:_____

Patient's Signature:_____

Date:_____

Practitioner's Signature:_____

Patient's Representative (if the patient is a minor)_____