**Consent to Treatment**

By signing below, I do hereby voluntarily consent to be treated by Acupuncture in Vancouver Inc.. I understand that Licensed Acupuncturists practicing in Oregon & Washington are not primary care providers. It is recommended that all patients have a primary care provider and that all patients provide medical records from this provider upon request. All information will be held in strictest confidence according to HIPPA regulation. I have read the above\_\_\_\_\_\_\_\_\_(initial)

**Acupuncture/TDP lamp:** I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or by 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 have been made 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 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 the treatment at any time. I have read the

above\_\_\_\_\_\_\_\_\_\_(initial)

**Electro-Acupuncture/Transcutaneous electro stimulation:** I understand that I may be asked to have electro stimulation with the acupuncture or transcutaneous electro stimulation (no needles used). I have been made aware that certain adverse effects may result which 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/these therapies. I have read the above\_\_\_\_\_\_\_\_\_\_(initial)

**Massage/Acupressure/Cupping/Qigong** (energetic healing): I understand that I may be asked to have massage, acupressure, cupping, or Qigong healing techniques as part of my treatment. I have been made aware that certain side effects may result. These include, but are not limited to: local bruising, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I am free to stop the treatment at any time. I have read the above\_\_\_\_\_\_\_\_\_\_\_(initial)

**Chinese herbs:** I understand that substances from the Oriental materia medica may be recommended to me to treat bodily dysfunction or disease or to modify or prevent pain perception and to normalize the body’s physiological functions. I understand that I am not required to take the substances but must follow the directions for administration and dosage if I do decide to take them. I have been made aware that certain side effects may result.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 will suspend taking them and call Acupuncture in Vancouver Inc. as soon as possible. I have read the above\_\_\_\_\_\_\_\_\_\_\_(initial)

I have received a copy of Patient Notification of Qualifications and Scope of Practice which is a required form from the State of Washington (last page of forms). The following statement is also required by the State of Washington: I acknowledge that if I may have a potentially serious disorder, Acupuncture in Vancouver requests a consultation or recent diagnosis from a physician or physician’s assistant, osteopathic physician or osteopathic physician’s assistant, naturopath or ARNP on that potentially serious disorder. I understand the services and techniques the East Asian medicine practitioner is authorized to provide will not resolve my underlying potentially serious disorder(s). I acknowledge that failure to pursue treatment from my primary health care provider may involve risks, nonetheless, I do not wish to authorize a consultation or to provide a recent diagnosis from such a primary health care provider and wish to continue with treatment.\_\_\_\_\_\_\_\_\_(initial)

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Signature of patient or guardian Date

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Name {Please Print)

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