wellbeing

Consent to Treatment

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the *Oriental Materia Medica* by a Licensed Acupuncturist at Wellbeing. 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 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 at certain points on 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 a very low risk of pneumothorax and spontaneous miscarriage also exists with the use of certain acupuncture points. I understand that no guarantees concerning acupuncture's use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct 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 the clinic or my acupuncturist as soon as possible.*

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure, Tui-Na, or 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.

Acupuncture Facial Rejuvenation and Chinese Facials: I understand that, should I decide to have one of these facial treatments, certain adverse side effects may result. These may include, but are not limited to bruising, puffiness, redness, irritation, bleeding, and pain. I understand that I may refuse this treatment.

Cupping: I understand that I may be asked to have cupping administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to bruising, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by another licensed medical professional.

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: _____ **Date:** _____

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

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