



**Consent to Treatment Form**

I do hereby voluntarily consent to be treated with acupuncture, medicinal herbs and TCM at Andrew Wu L.Ac Inc.

**(Initial)**\_\_\_\_\_ **Acupuncture/Moxibustion:** I understand that acupuncture is performed by the insertion of sterile single use needles through the skin or by the application of heat to the skin 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. Acupuncture and Moxibustion are typically safe methods of treatment, however certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, dizziness, 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.

**(Initial)**\_\_\_\_\_ **Pregnancy:** I will notify the treating provider should I become pregnant or if I am in the process of trying to become pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

**(Initial)**\_\_\_\_\_ **Chinese Herbs:** I understand that Chinese medicinal herbs 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, nausea & vomiting, 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 provider as soon as possible.***

**(Initial)**\_\_\_\_\_ **Acupressure, Tui-Na Massage, Qi Gong:** I understand that I may also be given acupressure/tui-na massage and/or Qi Gong 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.

**(Initial)**\_\_\_\_\_ **Cupping, Gua Sha, Lance Therapy :** I understand that I may also be given cupping (the application of plastic cups with vacuum to the skin), Gua Sha (rubbing of the skin with a smooth object such as a porcelain spoon), lance therapy (using a lance to remove stagnant blood) as part of my treatment to modify or prevent pain perceptions and to normalize the body’s physiological functions. ***I am aware that these treatments are intended to cause minor bruising, and though unsightly, are not normally painful.*** However, 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 refuse the treatment or stop the treatment at anytime for any reason.

**(Initial)**\_\_\_\_\_ **Treatment by Trainees:** I understand that I may have treatment performed by an acupuncture trainee supervised by Andrew Wu L.Ac. Before any treatment by trainee is performed, the patient will be verbally notified and asked by said trainee. I understand that I may refuse treatment by the trainee for any reason.

**(Initial)**\_\_\_\_\_ I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I do not expect Andrew Wu L.Ac to be able to anticipate and explain all possible risks and complications of treatment. 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 of anything regarding my treatment. I understand that my records will be kept confidential and will not be released without my written consent (unless in an emergency or by legal demand). I give my permission and consent to treatment.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_