**Information about your treatment & consent for treatment**

I hereby agree and consent to the performance of acupuncture and other Traditional Chinese Medicine procedures. I understand that such procedures may include, but are not limited to acupuncture, moxibustion, cupping, exercise therapy, Tui-Na (Chinese massage), Chinese or western herbal medicine, and nutritional counselling.

Acupuncture is a technique utilizing fine stainless steel needles inserted at specific points in the body to correct various ailments.

Moxibustion is the application of indirect heat by burning a stick of compressed Folium Artemisiae vulgaris, commonly known as Mugwort, over acupuncture points.

Cupping utilizes round suction cups over a large muscular area (such as the back) to enhance blood circulation to the designated area.

Tui-na is a form of Chinese body treatment (massage) used in facilitating healing and pain management. Occasionally there may be increased soreness at the sites of treatment on the day of, or day following treatment.

In all acupuncture treatments only sterile, disposable needles are used to ensure the safest acupuncture treatment possible. Acupuncture is a safe method of treatment, but may have some side effects, including bruising, numbness or tingling, dizziness or fainting, minor swelling, bleeding, a hematoma (bruise) may occur at the site of insertion and may last a few days. A sensation of lightheadedness may occur after acupuncture treatment. I will immediately notify the acupuncturist if I experience any symptoms or problems.

I understand that I should not make significant movements while the needles are being inserted, manipulated, retained, or removed.

I am relying on the TCM practitioner to exercise judgment during the course of my treatment, trusting that, based upon facts then known, this treatment plan is appropriate and in my best interests. I understand that acupuncture and other Chinese Medicine procedures are not substitutes for treatment by my medical doctor. Also, at any given time throughout the treatment, I may request the practitioner to stop, modify or change the treatment plan.

This is NOT a waiver form. It is part of our “duty of care” to you that we inform you of any material (pertinent) risks associated with professional treatment techniques. **P.T.O**

In very rare cases acupuncture has been reported as being associated with bodily infections or collapse of lung. Allergic skin reactions to massages oils, acupuncture needles, or topical applications are a possibility.

I state that I do not have the following conditions: pregnancy; cancer; Hepatitis B or AIDS; fits, faints or funny turns; bleeding disorders; pacemaker; local infections; artificial implants such as joint replacement, metal plates or breast implants; or am currently taking anticoagulants; I am not allergic to Metal**. If I have any of the above conditions, I have circled them and will discuss them with my practitioner.**

I understand that in the event of an emergency I may be required evacuate the building and will follow instructions given to me by AcuHerb staff.

In the event of incident requiring first aid I understand that all AcuHerb practitioners hold a current first aid certificate and will attempt to administer first aid to the best of their abilities until medical assistance can be sought.

If you wish to discuss any information provided in this form prior to signing, please bring it with you to your first consultation and discuss it with your practitioner.

If at any time during the course of your treatment to have any queries, complaints or comments, please direct them to one of our staff who will attempt to address them promptly.

By voluntarily signing below I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby certify that I have read this entire form, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions and that I consent to treatment with the modalities described above. I intend this consent form to cover the entire course of treatment to be performed for my present condition.

I have read this form, understand the information it contains and give my consent to treatment.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

If patient is under the age of 18, please have a parent or guardian sign below:

I have read this form, understand the information it contains and give my consent to treatment for:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient’s name).

Parent/guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_