

## Informed 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 Jayne Dabu, LAc Dipl. Ac a licensed acupuncturist at Lotus Acupuncture and Holistic Health Clinic. I accept that No Guarantee is made concerning the results of my acupuncture treatment, and I have been informed that I may stop treatment at any time.

I understand that methods or treatments may include but are not limited to acupuncture, moxibustion, cupping, bloodletting, electrical stimulation, Tui Na (Chinese massage), Gua Sha, Chinese or Western herbal medicine, nutritional counseling, and Nutritional Response Testing.

**Acupuncture/Moxibustion:** I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or 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 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.

**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/Western Herbs/Nutritional Supplementation:** 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 the same herbs/supplements may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. 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 effect 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 Jayne Dabu, L.Ac at 757.431.0053 as soon as possible.*

**Acupressure/Tui-Na Massage/Cupping/Gua Sha:** I understand that I may also be given acupressure/tui-na/cupping/gua sha 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.

**Electro-Acupuncture:** I understand that I may be asked to have electro-acupuncture administered with the acupuncture. 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.

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# Informed Consent To Treatment

(CONTINUED)

I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. \_\_\_\_\_initial

I understand it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records for the reasons listed above. \_\_\_\_\_initial

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. \_\_\_\_\_initial

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. \_\_\_\_\_initial

\_\_\_\_\_  
Patient Name (print)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Are you Pregnant?

*Jayne F. Dabu L.Ac.*  
\_\_\_\_\_  
Name of Licensed Acupuncturist

To be completed by patient representative , if patient is minor or legally or physically incapacitated

Patient Name \_\_\_\_\_

Patient's  
Representative \_\_\_\_\_

Relationship or Authority of  
Patient \_\_\_\_\_

Witness \_\_\_\_\_