ACUPUNCTURE / CHINESE HERBS INFORMED CONSENT TO TREATMENT

I, the undersigned, hereby voluntarily consent to be treated with acupuncture and/or substances from Oriental Materia Medica (Chinese Herbs) by a licensed acupuncturist at Purity Integrative Health. I understand that acupuncturists practicing in the state of Washington or Montana are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended.

**Acupuncture:** I understand that acupuncture is performed by the insertion of needles through the skin at certain points 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, infection, minor bleeding, needle sickness, broken needle, pain or discomfort at the site of insertion or 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.

**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.

**Acupressure/Tui-Na:** I understand that I may also be given acupressure/tui-na 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 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.

**Cupping/Gua Sha:** I understand that I may also be asked to have cupping/gua sha as part of my treatment to mobilize blood flow and promote healing. I am aware that certain side effects may result. These may include, but are not limited to: bruising, pain, discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may decline this treatment.

**Chinese Herbs:** I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

**WA/MT Scope of Practice:** The “scope of practice” for an acupuncturist in the states of Washington & Montana includes, but is not limited to the following list of techniques: Use of acupuncture needles to stimulate acupuncture points and meridians; Use of electrical, mechanical or magnetic devices to stimulate acupuncture points and meridians; Moxibustion; Acupressure/Tui-Na; Cupping; Dermal friction technique (gua sha); Infra-red; Sonopuncture; Laserpuncture; Dietary advice based on traditional Chinese medical theory; and Point injection therapy (aquapuncture).

**Patients that are pregnant or may be pregnant and patients that have severe bleeding disorders or pacemakers must inform the practitioner prior to 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. I give my permission and consent to treatment.

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Signature of patient (or guardian if under 18) Date

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Printed Name