Consent for Treatment

I, _____hereby voluntarily request to receive clinical services from an independent state licensed acupuncture physician at Positive Health, LLC. I understand that these services may include such types of treatment as acupuncture with or without electricity, moxibustion, cupping, therapeutic massage or myofascial therapy, nutritional/dietary counseling, herbal and nutritional therapy, homeopathic consultation, frequency specific microcurrent and lifestyle counseling. I acknowledge that no guarantees have been made to the effect of such examinations, treatments, therapy, or care of my condition. I further acknowledge that none of the above services are meant to be construed as the diagnosis or treatment of disease, but are designed to promote and/or restore the flow of vital energy throughout the body that is essential to wellness. I understand that prior to the beginning of any treatment procedure, I will receive an explanation of the nature and purpose of the treatment.

I understand that the possibility of adverse affects as a result of treatment is rare. These affects may include minor bruising from needle insertion (hematoma), or fainting during acupuncture that can be due to being over-hungry, tired or nervous. Burns and scarring are potential risks of moxibustion, and bruising is a common side effect of cupping. To prevent the puncture of a vital organ, careful attention will be taken with the insertion of all acupuncture needles in the areas of important viscera (chest, ribs, abdomen, and back). This clinic uses sterile disposable needles and maintains a clean and safe environment. I understand that when nutritional, herbal or homeopathic formulations are recommended, it is important to follow the guidelines set forth by my practitioner. I further understand that every effort to prevent herb-drug interactions is taken. Reactions to these formulations are rare, but can take place. If a reaction occurs, I agree to inform my practitioner, immediately, for further instructions.

I do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the practitioner to exercise judgment during the course of treatment. I understand that results are not guaranteed. I agree to be in communication with my practitioner if I have any questions regarding my treatment. I understand that I may refuse any and all services at any time. Finally, I understand that all clinical information will be kept strictly confidential as governed by state and federal regulations.

Patient Signature_____ ***Date*** _____

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