Lorene Harris Acupuncture

Bodywise Acupuncture & Traditional Medicinals Clinic

Consent to treatment form

Patient Name:_____ Date of Birth:_____

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by the licensed acupuncturist, Lorene Harris,L.Ac. I understand that acupuncturists practicing in the state of Minnesota are not primary care providers, and that regular primary care by a licensed physician is an important choice that is strongly recommended by this practitioner.

Acupuncture/ Moxibustion / Cupping: I understand that acupuncture is performed by the insertion of thin needles through the skin, moxibustion, the application of heat to the skin, and cupping, the application of glass cups to the skin (or a combination of these procedures) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or disease, to modify or prevent pain perception, and to normalize the body's physical functions. I am aware that certain adverse side effects may result. These may 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 I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion, as part of the therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or disease, 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 movements, 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 my practitioner as soon as possible.

Palpation: I understand that point and channel palpation is part of the treatment process to help the practitioner determine the best placement for needles. I am aware that palpation may be uncomfortable and may possibly aggravate my symptoms which existed prior to treatment. I understand that If I am uncomfortable, that I will communicate this discomfort so the practitioner may adjust their technique.

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.

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

I have carefully read and understand all 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. If patient is under 18 years, this form must be signed by a parent or guardian.

Signature:_____ **Date:**_____

Relationship to patient (circle one):

Self Parent Guardian Other:_____

Printed Name:_____**Date of Birth**_____

Address:_____

City:_____ **State:**_____ **Zip Code:**_____ **Phone:**_____