Informed Consent To Treatment Policies

I,_____, give consent to receive acupuncture treatments and other procedures associated with Traditional Chinese Medicine by Michelle Graves, L.Ac. and/or any guest acupuncturist working under her supervision. I understand that the methods of treatment may include, but are not limited to acupuncture, moxibustion, cupping, electric stimulation, Tui-Na massage, herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment but that it may have side effects, including, but not limited to bruising, numbness and tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Other risks of acupuncture treatment could include (although unusual and extremely rare) nerve damage and organ puncture (including lung puncture, or pneumothorax).

Although the clinic uses sterile, disposable needles and maintains a clean and safe environment, infection is another possible risk of treatment. Risks associated with moxibustion treatment may include burns and/or scarring, although unusual and rare. I understand that while this document describes major risks of treatment, other unanticipated side effects may occur. I do not expect the acupuncturist to be able to anticipate all possible complications from treatment, but I do wish to rely on the acupuncturist to exercise judgment during the course of treatment, which based upon the facts known and my condition, is in my best interests.

The herbs and nutritional supplements (which are from plant, animal, or mineral sources) that have been recommended are safe in the practice of Traditional Chinese Medicine, although some may be toxic if not taken as prescribed. Other possible side effects of herbal treatment are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I understand that some herbs may be inappropriate during pregnancy.

I understand that the herbs need to be prepared and consumed according to the instructions provided verbally and in writing. The herbs may have an unpleasant taste or smell. I will immediately notify my practitioner of any unpleasant effects associated with the consumption of herbal teas or products.

- **I will notify my practitioner if I am or become pregnant.**
- **I agree to follow all treatments only as recommended/ prescribed. If I am experiencing any side effects or difficulties I will notify the practitioner as soon as possible.**
- **I understand the practitioner and clinic staff my review my lab reports, but all my records will be kept strictly confidential and will not be released without my consent.**

By voluntarily signing below, I am demonstrating that I have read (or have had read to me) this consent to treatment and treatment policies, have been told about the risks of acupuncture and other procedures, and have had the opportunity to ask questions. I understand this consent is intended to cover my entire course of treatment for my present and future conditions for which I seek treatment at this office.

Patient's/Representative's Signature:_____**Date:**_____