Consent to Treatment

By signing below, I do hereby authorize April Enriquez, Licensed Acupuncturist at Stafford Acupuncture to administer any style of Traditional East Asian Medicine/Oriental Medicine relevant to my diagnosis and treatment, including but not limited to the following:

Acupuncture: I understand that acupuncture is performed by the insertion of needles through the skin 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. 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.

Moxibustion: I understand that heat treatments using Artemisia vulgaris ("moxa") involves putting moxa on the head of a needle while inserted in the skin, or directly on the skin. The heat generated from moxa treatments may involve a slight discomfort or leave a blister or scar on the skin. I understand that I may refuse this therapy.

Chinese Herbs: I understand that Chinese Herbal formulas 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 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 movement, or abdominal pain or discomfort. *Should I experience any problems which I associate with these substances, I should suspend taking them and call Stafford Acupuncture as soon as possible.*

Cupping: I understand that cupping may be used to promote circulation of qi through the meridians. Cups may produce a red/purple color on the area treated lasting for 1 – 5 days.

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.

Most conditions require an average of 6-12 treatments, although some will respond within 4-6 treatments and others may require a longer series – this depends on the severity and the chronic nature of the chief complaint.

I have been informed that I have the right to refuse any form of treatment. I understand the nature of the treatment, have been informed of the risks and possible consequences involved in the treatment, and have been given an opportunity to ask questions pertaining to the treatment. I also understand that there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I understand that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

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.

Signature: ____ **Date:** ____________________