Dragon Springs Acupuncture Phone: 845-532-6723

INFORMED CONSENT FOR ACUPUNCTURE & ORIENTAL MEDICINE TREATMENT

I hereby request and consent to the performance of procedures which are within the scope of practice of acupuncture and oriental medicine including, but not limited to acupuncture, electro-acupuncture, moxibustion, cupping, gua sha, and tui na (Chinese massage) by the acupuncturist at Dragon Springs Acupuncture.

I understand that acupuncture is a therapy based on the regulation of human energy called Qi. It is the insertion of fine needles into the body to stimulate healing and to reduce pain and is generally safe and effective. It is normal to feel temporary warmth, tight, sore or tingling sensations at the acupuncture site. While rare, acupuncture occasionally causes discomfort where the needles are inserted, bruising, nausea, or a few drops of blood upon the removal of a needle. Electro-acupuncture is the addition of a small electrical current to the needles, which may cause tingling, pulsing, or electrical sensation.

MOXABUSTION: I understand that moxabustion (moxa) is a type of heat therapy that involves burning the herb mugwort (*Artemisia Vulgaris)* at particular points and can be administered above the skin, on top of the needle, or on the skin. I understand that I should alert the practitioner if I experience discomfort or if the moxa becomes too hot. To the best of my knowledge I am not allergic to mugwort. Possible risks, while rare, may include a small burn and/or blister on the skin.

GUA SHA & CUPPING: I understand that gua sha and cupping are forms of therapy that allow the regulation of human energy. It involves applying ointment to the skin, followed by rubbing the skin with an implement or creating a strong vacuum seal with a cup on the skin. The desired effect is to create a temporary petichia to rise to the surface of the skin where the procedure is being performed. Petichia may last 1-5 days. Occasionally, bruising may occur due to the pressure of gua sha or cupping.

TUI NA: I understand that tui na is a form of Chinese massage based on the regulation of human energy. Specific areas of tightness and constriction of the body are accessed through touch by the use of rhythmic, gentle and/or firm pressure, rubbing and/or kneading. It's normal to feel tingling, temporary warmth, and/or pulsing sensations. Occasionally soreness may occur lasting up to 24 hours.

I understand that possible benefits of all procedures performed may include an improved balance of bodily energy which may increase feelings of well-being and decrease pain or other symptoms for which treatment is sought.

I further understand that I should consult my physician for the condition(s) being treated with acupuncture. In addition, I understand that my other healthcare providers may need to be contacted, especially when a condition needs to be co-managed with specialists. Coordination of care is for the purpose of managing health conditions in my best interest and assures the optimal outcome of treatment. Therefore, I give my authorization to my acupuncturist to contact my other healthcare providers when necessary.

I understand that the success and results of treatment are not guaranteed, that my participation in self-treatment may be necessary for best results, and that there are known and potential risks. I understand that I have the opportunity to discuss the nature of the procedures and the potential benefits and risks prior to treatment. I understand that some procedures may be inappropriate during pregnancy. If I suspect I am pregnant, I will immediately inform the acupuncturist. I choose to rely on the acupuncturist to exercise reasonable judgment, based upon known facts, and to act in my best interests.

I have read the above consent, I have also had an opportunity to ask questions about its content and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for the present condition and for any future condition(s) for which I seek treatment. I have the right to refuse or discontinue treatment at any time and understand that this refusal may affect the expected results.

_____	_____	_____
Client Name	Signature	Date
_____	_____	_____
Witness or Guardian	Signature	Date