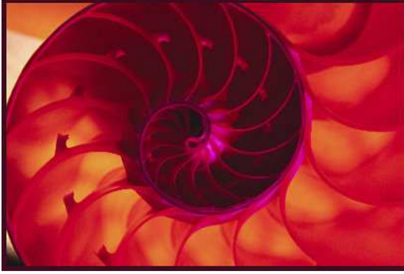

Peggy Johnston, L.Ac.
1787 W. 24 Ave, Eugene, OR 97405
Phone: 541-505-7708

Consent to Treatment

I, ____, hereby acknowledge that being treated with traditional Chinese medicine can include any of the following techniques:

1. Insertion of various styles and sizes of acupuncture needles into my body at various depths and locations.
2. A massage technique called "Gua Sha" may produce red or purple discoloration of the skin (similar to a bruise) which may remain for 1 to 7 days. There may also be a slight tenderness in the area treated.
3. A method called "cupping" involves placing glass cups over the skin to produce a vacuum and promote the circulation of "qi", or energy, through the meridians. Cupping may also produce skin discoloration and tenderness for 1 to 7 days after treatment.
4. Electro-acupuncture may be performed in cases of pain or stagnation in order to facilitate the movement of qi and blood.
5. The practitioner may leave press-balls, press-seeds, or magnets on my body. I will receive directions on how to care for, how to and when to dispose of these healing adjuncts.
6. I may also receive herbal prescriptions or recommendations pertaining to nutrition, diet, exercise, or other life-style habits. I understand that I am not required to take these herbal 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, 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 the clinic as soon as possible.

Consent to Treatment (continued)

The acupuncture practitioner must be advised if the patient has a pacemaker or a bleeding disorder, might be pregnant or has a contagious disease. If the patient has a potentially serious condition that is out of the practitioner's scope of practice, the patient will be referred to the emergency room or to a licensed physician with regard but not limited to: cardiac conditions including uncontrolled hypertension; acute, severe abdominal pain; acute undiagnosed neurological changes; unexplained weight loss or gain in a three month period; suspected fracture or dislocation; suspected systemic infections; any serious undiagnosed hemorrhagic disorder; and acute respiratory distress without previous history.

I have been informed that I have the right to refuse any form of treatment and that I have the right to terminate our treatments at any time. I understand the nature of the treatment, have been informed of the risks and possible consequences involved with this treatment, and was given the opportunity to ask questions pertaining to my treatment. I also understand that there is always the possibility of unexpected complication and I understand that no guarantee can be made concerning the results of the treatment. I am aware that acupuncture or traditional Chinese medicine is not a substitute for appropriate advice and care from a licensed medical doctor.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I give my permission and consent to treatment.

____

Your Signature (parent or guardian if minor)

____ ____________________

Print your name (printed patient name if minor) Date