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Consent to Treatment

I, _____, authorize Family Acupuncture to administer treatment of acupuncture and oriental medicine that is relevant to my diagnosis and treatment, including but not limited to the following:

1. Insertion of various styles and sizes of acupuncture needles into my body at various depths and locations.
2. Heat treatments using *Artemesia vulgaris* ("moxa") or a conventional heat lamp. Indirect moxibustion treatments involve putting moxa on the head of the needle or on top of a barrier such as salt or a slice of ginger. When direct moxa is used, the moxa is placed directly on the skin. The heat generated from the moxa treatments may involve slight discomfort or leave a blister or scar on the skin. With any type of heat there is always a risk of a burn.
3. A massage technique called "gua sha". This treatment leaves redness on the skin that can last for 1-5 days. Slight bruising and tenderness may persist after the treatment.
4. Cupping may be used to promote circulation of Qi (energy) through the meridians. Cups may produce a red/purple color on the area treated for 1-5 days.
5. Electrical stimulation of the needles may be used which produces a vibration or tapping sensation.
6. Bloodletting, alone or in conjunction with cupping, may be used to improve circulation in specific meridians. Lancets are inserted into the skin with a small amount of blood is expressed from the puncture.
7. Chinese Herbal Medicine, in various forms such as pills, capsules, extract powders, and raw herbs, to be administered orally and/ or topically. Some patients may experience side effects from their particular prescription.

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 with this treatment, and have been given an opportunity to ask questions pertaining to the treatment. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment.

Signature of patient: _____ Date: _____

Printed name of patient: _____

Practitioner signature: _____ Date: _____