

# SHIVA HEALTH SERVICES

## ORIENTAL MEDICINE CONSENT FORM

I, \_\_\_\_\_, give my consent to have acupuncture procedures performed on me. Acupuncture and Traditional Chinese Medicine (TCM) have been practiced for more than 2,5000 years and used effectively in various forms by more than one-fourth of the world's population (China, Korea, Japan, and many other Asian and European countries).

I understand that there is no implied or stated guarantee of success of a specific procedure, treatment or series of treatments herein authorized by me, and there are no guarantees that acupuncture will cure my condition. The focus of the work is to encourage a balance in the natural energy flow of the body, based upon TCM diagnostic techniques.

I also understand that the acupuncture treatment or herbal consultation is performed by a state licensed and nationally certified practitioner and is not performed by a medical doctor.

The acupuncture procedure consists of diagnostically feeling the pulse, observing the tongue, and inserting fine, pre sterilized stainless steel needles into the skin at various acupuncture points. When applicable, treatment may also include the use of one or more of the following: acutonics® (sound frequencies applied through tuning forks), acupressure, moxibustion ( a warming herb placed above the surface of the skin), the application of Chinese herbs to the skin surface in the form of a poultice, mask, or in a moisturizer base, electro-stimulation, TDP (far-infrared heat Lamp), cupping with glass jars, ear beads, or ear tacks.

I understand there may be some discomfort at the time of needle insertion. This will pass quickly. Occasionally, some lightheadedness may occur. This is more common if one is very hungry and/or tired. In addition, superficial capillaries may rupture causing local bruising and slight bleeding when the needle is withdrawn.

Only sterile, disposable needles are used, and infections are rare. I will let the acupuncturist know if I am experiencing any discomfort. The acupuncturist knows what to do and can easily make adjustments to my treatment needs. I am aware that there may be temporary aggravation of pre-existing symptoms in the healing process.

I realize that I may discontinue treatment at any time. I hereby certify that I have read the above statement, have had my questions answered to my satisfaction, understand the provisions described herein, and do hereby give consent for treatment.

Patient Signature \_\_\_\_\_

Date: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_

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Provider's Statement: I certify that I have informed the above-mentioned patient of the following: the nature, purpose, and possible consequences of the procedure, risks involved, possibilities of complications and possible alternative methods of treatment.

Providers Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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