CONSENT TO TREATMENT

By signing below, I do hereby voluntarily consent to be treated with acupuncture and the associated modalities below by Susan Wilmoth, L.Ac.

Acupuncture
I understand that acupuncture is performed by the insertion of fine needles through the skin at certain points on 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 have been made aware that certain adverse side effects may result. These include, but are not limited to local bruising, minor bleeding, fainting, pain or discomfort and the possible aggravation of symptoms existing prior to treatment. I understand that there are no guarantees concerning the results of acupuncture and that I am free to stop treatment at any time.

Electro-Acupuncture
I understand I may be offeredelectro-acupuncture as a part of my treatment. I have been made aware that certain adverse side effects may result which 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 decline or stop this therapy at any time.

Moxabustion
I understand that I may be offered moxabustion as a part of my treatment. It is performed by the application of heat above the skin using a lighted form of moxa at certain points on 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 understand that with moxabustion there is a risk of burning or scarring. I understand that I may decline or stop this therapy at any time.

Chinese Herbs/Supplements
I understand that substances from the Oriental Materia Medica and/or nutritional supplements 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 am not required to take these substances but if I chose to, I must follow the directions for administration and dosage. I have been made aware that certain side effects may result from taking these substances. These may include, but are not limited to changes in bowel movements, abdominal cramping or discomfort and possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems that I associate with these substances, I should discontinue taking them and call the prescribing practitioner as soon as possible.

Massage Therapy, Cupping Therapy, & Guasha
I understand that I may also be offered massage (shiatsu, tuina, or cupping) or guasha as a part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I have been made aware that certain adverse side effects may result from massage, cupping or guasha. These may include but are not limited to muscle soreness, bruising, and possible aggravation of symptoms existing prior to treatment. I understand that I may decline or stop any of these therapies at any time.

I understand that Licensed Acupuncturists practicing in the state of Oregon are **not** primary care providers and that regular primary care by a licensed M.D., N.D. or D.O. is an important choice that Susan Wilmoth, licensed acupuncturist, strongly recommends.

I understand that there may be other treatment alternatives, including treatments offered by licensed physicians and other practitioners. 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.

Signature: _____ Today's Date: _____

Printed Name: _____ Birth Date: _____

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