GRAYS HARBOR
Community Acupuncture

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COMMUNITY ACUPUNCTURE
403 W State Street, Suite 102 • Aberdeen, WA 98520
360-589-7148 • www.reed-acupuncture.com

TREATMENT CONSENT FORM

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist at Reed Acupuncture & Eastern Medicine LLC, Grays Harbor Community Acupuncture, or any of its affiliates. I understand that acupuncturists practicing in the state of Washington are not primary-care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of 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 am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time. I understand that the clinic uses sterile, disposable needles.

I understand that it is important to notify the practitioner if I have a pace maker.

I understand that it is important to notify the practitioner if I am pregnant (female patients).

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I give my permission and consent to treatment.

Signature:_____ **Date:**_____

Indicate relationship if signing for patient:_____