Red Aspen WELLNESS

Consent to Treatment Form

UNDER TREATMENT COURSES IT IS ADVISED YOU ALERT THE PRACTITIONER IF:

1. YOU ARE PREGNANT OR ARE TRYING TO GET PREGNANT
2. HAVE METAL OR PROSTHETICS IN YOUR BODY
3. HAVE EPILEPSY

By signing below, I do herby voluntarily consent to be treated with acupuncture and/or substances/methods allowable by the state of Colorado by a licensed acupuncturist. I understand that acupuncturists practicing in the state of Colorado are not primary care providers and the regular primary care by a licensed physician is important. I understand I may verbally veto a therapy below per my comfort level and my own best judgement. Nothing is ever forced upon me in this clinic.

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) 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 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. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture/moxa treatment at any time.

***Direct Moxibustion*:** I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

***Chinese Herbs*:** I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to moderate or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do. 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 of these problems, which I might associate with these substances, I will suspend taking them until I speak with the practitioner who prescribed them.

Acupressure/Tui-Na Massage: I understand that I may be given acupressure or tui-na as part of my treatment to moderate or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects might result. These include but are not limited to: bruising, sore muscles or aches, and possible aggravation of symptoms. I understand I may stop this treatment at any time.

***Electro-Acupuncture*:** I understand that I may be asked to have electro-acupuncture administered with the needles. I am aware that certain adverse side effects may result from this treatment. These include but are not limited to, electrical shock, pain or discomfort and the possible aggravation of symptoms. I understand I may stop this treatment at any time.

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 treatments.

Injection/Biopuncture: I understand that I may accept injection/therapy and risks such as infection and puncture of structures such as nerves, vessels and organs is possible. Allergic reactions are unheard of but possible. METAL or PROSTHETIC parts shall be made aware of ahead of time. Risks and sterility are in-line with acupuncture.

Signature_____ Date_____