Hp
Medicine

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CONSENT TO TREATMENT – DISCLOSURE OF RISKS, AUTONOMY AND EXPECTATIONS

RISKS - Risks could include, but are not limited to the following:
ACUPUNCTURE - local bruising, minor bleeding, fainting, pain or discomfort, preterm labor, pneumothorax
AURA PHOTOGRAPHY - generally safe and might not be appropriate for everyone
AURICULAR THERAPY – ear tenderness, electrical shock, light-headedness, dizziness, headache
BODY SCANS / NEO-BIO-ENERGETICS - generally safe and might not be appropriate for everyone
CUPPING / GUA SHA - skin bruising, touch and temperature sensitive
CRYSTAL HEALING - light-headedness, dizziness, headache
ELECTRO-STIMULATION: electrical shock, pain or discomfort, aggravation of symptoms existing prior to treatment.
HERBS - bowel movement changes, abdominal pain, discomfort
HYPNOFERTILITY / HYPNOTHERAPY - headache, drowsiness, dizziness, anxiety, distress, false memories
MASSAGE - muscle soreness, pain and discomfort. Skin may be bruised, touch, temperature sensitive
MOXIBUSTION / TDP LAMP – skin blister, burns or scars
QHHT / PAST LIFE REGRESSION – headache, drowsiness, dizziness, anxiety, distress, false memories
SPRITUAL GUIDANCE - generally safe and might not be appropriate for everyone
EXPECTATIONS – I understand most conditions require multiple treatments. The efficacy of treatment depends on overall health, severity and term of chief complaint. I understand no guarantee can be made concerning the results of treatment and there is always a possibility of an unexpected complication. There may be other treatment alternatives, including treatment offered by a licensed physician.
I understand that acupuncturists practicing in the state of Colorado are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by the practitioner(s).
AUTONOMY - I understand I have been informed of the above risks and expectations, I may ask my practitioner for a more detailed explanation and I have the right refuse any form of treatment offered.

AFFIRMATION

With complete understanding of the risks, I grant my permission and consent to the performance of all of the above procedures, therapies and treatments provided by the practitioner(s).

NAME PRINTED_____**RELATIONSHIP**_____

SIGNATURE _____**DATE**_____