CONSENT FORM

This is a medical consent form for the clinic of Sheridan Richardson, L.A.c.

Acupuncture: Acupuncture is performed by the insertion of fine needles through the skin and/or by the application of heat to the skin a points on or near the surface of the body to treat bodily dysfunction or diseases, to modify or treat pain perception, and to normalize the body's physiological functions. There may occasionally be adverse side effects such as: local bruising, minor bleeding, fainting, pain or discomfort, the possible aggravation of symptoms existing prior to acupuncture treatment and very rarely lung puncture (pneumothorax).

Indirect Moxibustion: With this therapy there is a minimal risk of burning or scarring.

Electro-Acupuncture: Electro-Acupuncture may be administered with the acupuncture. There may be certain adverse side effects such as: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment.

Chinese Herbs: Chinese herbs and substances may be recommended to treat bodily dysfunction or diseases or to modify or prevent pain perception and to normalize the body's physiological functions. Patients must follow the directions for administration and dosage. There may occasionally be adverse side effects such as: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *With any problems associated with these substances, patients should suspend taking them and call Sheridan as soon as possible.*

Acupressure/Tuina/Shaitsu massage: Massage techniques are used to modify or prevent pain perception and to normalize the body's physiological functions. There may be certain adverse side effects such as: muscle soreness or achiness and the possible aggravation of symptoms existing prior to treatment.

I consent to treatment with the above modalities by Sheridan Richardson, L.A.c. I have had the above information explained to me and I have had my questions answered. I understand that there are no guarantees concerning treatment. I understand that there may be other treatment alternatives, including treatment that might be offered by a licensed physician. I understand that I am free to refuse or stop treatment at any time.

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Patient Signature **Date**

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Printed Name **Date of Birth**