Tracy Andrews, LAc
3133 NE Prescott Street
Portland OR, 97211

INFORMED CONSENT FOR TREATMENT

*Please **read and initial each statement**, indicating that you have read, understood, and agree. Please ask if you have questions. This form must be signed before we can begin treatment.*

If you prefer to have your practitioner read through this form with you and explain each section, please ask!

____ I hereby request and consent to treatment for myself (or the below-named patient for whom I am legally responsible) by the acupuncturist named below with procedures and techniques including but not limited to: acupuncture, moxibustion, cupping, bleeding therapy, gua sha, breathing techniques, exercise therapy, Tui-Na (Chinese massage), somatic re-education, craniosacral and/or visceral therapy, Chinese or western herbal medicine, lifestyle suggestions, and nutritional counseling.

____ I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Unusual risks, which the acupuncturist takes careful precautions to avoid, include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is a possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. I understand that I should not make significant movements while the needles are being inserted, retained, or removed.

____ I understand that craniosacral methods may be contraindicated for concussion, hemorrhage, stroke, or blood clots and state that I am not currently experiencing any of these conditions to the best of my knowledge or I have notified my practitioner of these conditions.

____ I understand that visceral therapy methods may be contraindicated for recent injuries or surgeries to the abdomen or thorax and for tumors in the abdomen or thorax, and state that I am not currently experiencing any of these conditions to the best of my knowledge or I have notified my practitioner of these conditions.

____ Side-effects of cupping, bleeding and gua sha may be bruising or temporary skin discoloration. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I understand that I may opt out of these treatments at any time.

____ The herbs and nutritional supplements (which are from plant, mineral, and animal sources) that have been recommended are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that the herbs need to be consumed

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according to the instructions provided orally and in writing.

____ I will immediately notify my practitioner of any effects associated with the consumption of the herbs or other supplements. I will keep the acupuncturist informed of my medications and other supplements to reduce the risk of herb-drug interactions.

____ I have stated all my known medical conditions and take it upon myself to keep the acupuncturist caring for me updated on my physical health. **I will notify the acupuncturist who is caring for me if I am or become pregnant, or I have a bleeding disorder. I will notify the acupuncturist of any significant changes in my health, or new diagnoses by my primary medical physician.** I understand that my acupuncturist encourages me to see a primary medical physician in conjunction with treatment by the acupuncturist. I release the acupuncturist from responsibility and liability for any adverse reactions resulting from disclosed and undisclosed conditions.

____ I do not expect the acupuncturist to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment. I understand that results are not guaranteed.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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 have had the opportunity to read this form and my questions are answered to my satisfaction. I hereby consent to the treatments initialed above.

Printed Name:_____

Printed Name of Patient Representative:_____

Signature of patient or patient representative:

_____Date:_____