Michelle Sturm, ND, LAc
541-383-5883

Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with Naturopathic medicine, acupuncture and/or substances from the Western or Oriental Materia Medica by Dr. Sturm, an Oregon licensed Naturopathic Doctor and Acupuncturist and her clinic, Coeur, LLC.

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.

Naturopathic Manipulation: I agree to spinal assessment and necessary spinal manipulation if recommended by my licensed Naturopath. I understand that I may refuse this treatment or stop this treatment at any time.

Western and Chinese Herbs: I understand that substances from the Western and/or Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify 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 decide to take them. I am aware that certain adverse side effect 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 problems, which I associate with these substances, I should suspend taking them and call Dr. Sturm as soon as possible. I agree to inform Dr. Sturm of any other medications, herbs or supplements I am currently taking.*

Acupressure/Tui-Na Massage and cupping: I understand that I may also be given acupressure/tui-na massage or cupping as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: demarcation, bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

I understand that there may be other treatment alternatives, including treatment offered by another licensed physician. 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 give my permission and consent to treatment.

Signature: _____Date:_____
Patient's Name: _____Date of Birth:_____/_____/_____
Relationship to Patient: _____
Address:_____
City: _____ State: _____Zip Code: _____Phone: _____
Insurance Carrier (if applicable): _____
Primary Insured's Name: _____
Primary Insured's Date of Birth: ____/____/_____
Insurance Policy ID#: _____
Group #: _____
Email: _____