Jessica Clayton
D.Ac, L.Ac (MUIH ’12-’19)

INFORMED CONSENT TO ACUPUNCTURE TREATMENT

I, the undersigned, understand that methods of treatment used in this practice may include but are not limited to, acupuncture, acupressure, pricking, moxibustion, cupping, gua sha, qi gong and Chinese medicine nutritional counseling.

I understand that acupuncture, moxibustion, cupping and pricking are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, or soreness at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting or broken needle. Infection is possible, although the practice minimizes this by using alcohol, single-use sterile needles, and maintaining a safe and clean environment. Potential risks of moxibustion heat therapy are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha, or dermal friction. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatment.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process. I will notify the practitioner if I have any known bleeding disorders or if I have a cardiac pacemaker.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise her judgment in my best interest during the course of treatment, based upon the facts then known.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred or carried out at this practice. I hereby release Jessica Clayton, D.Ac, L.Ac from any and all liability which may occur in connection with the above mentioned procedures. I understand I am free to withdrawal this consent and discontinue participation in these procedures at any time.

CANCELLATION POLICY: I have been informed of the fees for service, and I understand that payment is due when the services are provided. If I do not cancel an appointment at least 24 hours in advance, then I am liable for the full fee of treatment.

By signing below, I confirm that I have read or have had read to me, and understand the above Consent to Oasis of Harmony Wellness, LLC have been told about and understand the risks of each of the methods of treatment, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment from my present condition and for any future condition(s) for which I seek treatment.

PATIENT NAME (PRINT)

PATIENT REPRESENTATIVE NAME (PRINT)

PATIENT SIGNATURE

DATE

PATIENT’S REPRESENTATIVE SIGNATURE (IF APPLICABLE)

DATE

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