CONSENT FORM FOR ACUPUNCTURE & ORIENTAL MEDICINE

Scope of Practice

The "scope of practice" for an Acupuncturist includes but is not limited to the following list of techniques:

Use of acupuncture needles to stimulate acupuncture points and meridians
Use of electrical, mechanical or magnetic devices to stimulate acupuncture points and meridians
Acupressure – Palpating acupuncture points and placing pressure on those points
Laserpuncture – Using a cold/hot laser on acupuncture points
Tui Na – Using massage like techniques on areas of pain
Gua sha – Scraping of skin using a plastic or porcelain instrument
Cupping – Using glass/plastic cups on certain areas of the body
Moxibustion – Using a warming herb on acupuncture points

I recognize the potential risks/side effects and benefits of these procedures as described below:

Potential risks/side effects may include, but are not limited to the following:

Pain following treatment of needle insertion area
Swelling following treatment of needle insertion area
Temporary discoloration of the skin using acupuncture, cupping, gua sha, moxibustion, tui na
Aggravation of symptoms existing PRIOR to the treatment
Minor bruising
Broken Needle
Infection
Needle Sickness

Moxibustion may result in a minor burning sensation and/or the possibility of a burn
Cupping may cause burning of the skin, bruising of the skin, blistered skin eruptions, bleeding
Gua sha may result minor bleeding and/or bruising of the skin

NOTE: Patients with a bleeding disorder, pacemaker, seizure disorder, or women who are pregnant, MUST notify the practitioner.

Potential benefits may include, but are not limited to the following:

Drugless relief of presenting symptoms
Improved general health
Elimination of presenting problems
Reduction of pain and associated symptoms

With the knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me regarding cure or improvement of my condition. I have been informed to see a medical doctor prior to treatment and hereby release Linyana E. Gipson from all liability which may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate care.

I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

____ _____________________

Patient/Guardian Signature Date