Ageless Acupuncture

Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and other procedures within the scope of practice of Traditional Chinese medicine by Cheryl McCarthy, L.Ac. and/or any other licensed acupuncturists serving as back-up *for* Cheryl McCarthy. I understand that acupuncturists practicing in the state of South Carolina are not primary care providers and that regular primary care by a licensed physician is strongly recommended by this clinic's practitioners.

Acupuncture: I understand that acupuncture is performed by the insertion of needles through the skin at acupuncture points on 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, hematoma, nausea, residual soreness, tingling near the needling sites that last a few days 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.

Indirect/Direct Moxibustion and other heat therapies: Moxibustion is the application of burning moxa (compressed or loose mugwort herb) on or near acupuncture points or regions of the body. Heat therapy is beneficial with chronic pain and helps to boost the immune system. I understand that if I receive heat therapy (moxibustion or TDP lamp) as part of therapy, there is a risk of burning and scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that Chinese herbal products (which are from plant, animal, and mineral sources) 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 Cheryl McCarthy as soon as possible.*

Acupressure/Tui-Na/Shiatsu Massage: I understand that I may also be given acupressure/tui-na/shiatsu massage 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: 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.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. Electro-acupuncture is a procedure where some of the acupuncture needles are connected to clips that are connected to an electrical source that generates a light pulse of electricity. The source of this electricity is a 9-volt battery. This technique is used to relieve pain and move qi and blood. I am aware that certain adverse side effects may result that may include, but are not limited to electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. *If I have a pacemaker, I must share that information with my practitioner*. I understand that I may refuse or stop this treatment at any time.

Cupping: Cupping refers to an ancient Chinese practice in which a cup is applied to the skin and the pressure in the cup is reduced (by using change in heat or by suctioning out air), so that the skin and superficial muscle layer is drawn into and held in the cup. In some cases, the cup may be moved while the suction of skin is active, causing a regional pulling of the skin and muscle (the technique is called moving cups). Cupping is used to access deeper musculature and improve circulation. It is commonly used to relieve pain and can help with respiratory problems. Bruising is a common side effect although the bruises are usually not sore and fade within a week. I understand that I may refuse or stop this treatment at any time.

Liniments: Topical creams or oils are sometimes used to promote circulation, move energy, and warm or cool an area of the body. Side effects can include an allergic reaction such as a rash or itching of the skin. Please inform your practitioner of any allergies you have. I understand that I may refuse the use of liniments.

There is no guarantee that acupuncture will help any condition. Certain medications and social habits may decrease the beneficial effects of acupuncture. These include the use and abuse of alcohol, tobacco, steroids, painkillers, narcotics, stimulants, antidepressants, pharmaceuticals and illegal drugs.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I have had the opportunity to discuss with the acupuncturist the nature and purpose of acupuncture and I understand that I may ask my practitioner for a more detailed explanation at any time. I also certify that I have informed my acupuncturist of all known physical, mental and medical conditions, and medications, and I will keep her updated on any changes. *I understand that I should inform my acupuncturist prior to being treated if I believe I might be pregnant.* I do not expect the acupuncturist to be able to anticipate and explain all risks and complications. I wish to rely on the acupuncturist to exercise judgment which the acupuncturist feels at the time is in my best interest, based upon the facts then known, during the course of the treatment.

To be completed by patient	**To be completed by patient's representative**
Patient	Printed Name of Patient
Signature	Relationship to patient
Date	Date
	Printed Name of Representative
	Signature of Representative