sedonaranch.org

where healing awaits you

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Consent Form for Office Treatment

By signing below, I do hereby voluntarily consent to be treated with Acupuncture, Traditional Chinese Medicine, and Herbal Medicine by Licensed Acupuncturist Fernanda Durlene.

Acupuncture: 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. _______

Moxibustion: I have been informed and understand that moxa treatment is safe if done properly as instructed, but it may likely leave burns and scars on the treated area.I will notify my acupuncturist who is caring for me if I am or likely to be pregnant, and also if I have tendency of slow wound healing; for example diabetes, keloids, etc. I understand that immediate results are not guaranteed. By voluntarily signing below, I show that I have read the above consent to treatment, or it has been read to me, and I have been told about the risks and benefits of moxa treatment and have had an opportunity to ask questions.________

Cupping: have been informed and understand that cupping treatment is safe if done properly as instructed, but it will leave bruising and marks on the treated area for a few days or maybe even longer. I understand that I may refuse this therapy . _______

Herbs: I understand that substances from the Homeopathic Materia Medica may be recommended to me to heal bodily symptoms or dysfunctions, 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 use of Homeopathy. Should I experience any problems, which I associate with these substances, I should suspend taking them and call Sedona Ranch immediately. ______

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na 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. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment. ______

I acknowledge that the proposed procedure, the potential risks and benefits, and the possible complications of such procedure have been explained to me as well as the possible risks and benefits of not undergoing this procedure. I further acknowledge that alternative methods of available treatment were discussed with me, and that I was given adequate opportunity to ask questions pertaining to this procedure and the alternative methods. No guarantee or assurance has been given by anyone as to the results that may be obtained from this procedure.
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:_____________

Signature:______________________________ Date:_____________

Signature of parent or guardian if patient is a minor (under 18 years of age)

Name: __________________________________Date of birth: _________________